

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County... Allegheny
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 83 yrs. mo. 1 da.
 Hospital, institution, or street address where death occurred
220 Fulton St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Allegheny
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 220 Fulton St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Minnie Wilhelmina Aberle

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife George Aberle
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct 30 1863
 8. AGE: Years 83 Months 1 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Ind
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George C. Smith

13. Birthplace Germany

14. Maiden name Margaret

15. Birthplace Germany

16. Informant Adam Smith

Address Cumberland

17. Burial Date thereof Dec 3 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Willoughby Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Dec 3 46 19 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946 at 5 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Nov 30 1946
 and that I last saw him alive on Nov 30 1946

Immediate cause of death Cerebral vascular accident DURATION 3 days

Due to

Due to

Other conditions Sensibility, Generalized 2 yrs.
arteriosclerosis, arthritis
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Hevaskis Jr. M.D.
Baltimore Avenue
 Address Cumberland Date signed 12/2/46

RECEIVED

DEC 10 1946

BUREAU V 8

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (924)

11601

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

814 Buckingham Road-The Dingle

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)Street No. 814 Buckingham Road-The Dingle
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Frank Ockerman Armstrong

3.(b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>	
6.(b) Name of husband or wife <u>Ada Lloyd Armstrong</u>			
7. Birth date of deceased (mo., day, yr.) <u>Sept. 13, 1880</u>			
6.(c) If alive, give age..... years			
8. AGE: Years <u>66</u>	Months <u>3</u>	Days <u>13</u>	If less than one day hrs. min.

9. Birthplace Bedford, Penna.
 (Town, county, and state)10. Usual occupation Retired11. Industry or business Real Estate Business12. Name Thomas Armstrong13. Birthplace Frostburg, Md.14. Maiden name Mary Carpenter15. Birthplace Bedford Co. Penna.16. Informant Mrs. Ada ArmstrongAddress The Dingle, Cumberland, Md.17. Burial Date thereof Dec. 28, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Zion Cem.Location Mt. Zion, Penna.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Dec 28 19 46
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 19 46 at 1:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 46 to Dec. 26, 19 46
 and that I last saw him alive on Dec. 22, 19 46Immediate cause of death
Chronic Myocarditis
Coronary Thrombosis

DURATION

1 yr.
8 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

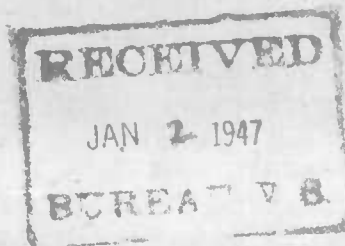
23. SIGNATURE J. B. Jones M.D. M. D. or otherAddress Medical Bldg Date signed 12-27-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98

11602

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL, CUMBERLAND, MD.
How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State W. VA. County MINERAL
City or town ELK GARDEN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

JACKSON ARONHALT *Aronhalt*

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife NELLIE BIGGS

7. Birth date of deceased (mo., day, yr.) July 5, 1869 6. (c) If alive, give age, years

8. AGE: Years 77 Months 5 Days 1 If less than one day, hrs. min.

9. Birthplace W. VA. (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

12. Name ANDREWS ARONHALT

13. Birthplace W. VA.

14. Maiden name Eliza Evans

15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL

Address Cumberland Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 12/9/46

Cemetery or crematory Aronhalt Cemetery

Location Hartmonsville, Grant Co, W. Va.

18. Funeral director O. F. Sharpless

Address Blaine, W. Va.

19. Dec. 9, 46 J. P. Frankel, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 6 19 46 at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 19 46 to Dec 6 19 46 and that I last saw him alive on Dec 6-46 19 46

Immediate cause of death Cardiac vascular collapse -

Due to operation - amputation of leg -

Other conditions Senile gangrene

(Include pregnancy within 8 months of death)
Major findings of operations Gangrene of leg Date of op. Dec 3-46

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. G. Gracie M. D. or other

Address Cumberland Date signed Dec 7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

BUSINESS

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

11603

Reg. Dist. No.

40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERALCity or town PIEDMONT
(If outside city or town limits, write RURAL and give nearest town)Street No. 101 ASHFIELD ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

GEORGE W. BERISFORD

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEMARRIED6. (b) Name of husband or wife EFFIE COWAN7. Birth date of deceased (mo., day, yr.) NOVEMBER 30, 18706. (c) If alive, give age 72 years8. AGE: Years Months Days If less than one day
76 1 0 hrs. min.9. Birthplace WEST VIRGINIA
(Town, county, and state)10. Usual occupation JEWELER

11. Industry or business

12. Name THOMAS BERISFORD13. Birthplace ENGLAND14. Maiden name CATHERINE MCGOVERN15. Birthplace NEW YORK16. Informant MEMORIAL HOSPITALAddress CUMBERLAND MARYLAND17. BORIAL Date thereof 1-2-47
(Burial, cremation, or other) (month) (day) (year)Cemetery or crematory PhilosLocation Westport Md.18. Funeral director W. Harold FleenorAddress Piedmont. W. Va.19. Jan 1, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 30, 1946 at 5:25P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12:30 to 12:30
and that I last saw him on 12:30

Immediate cause of death

Coronary ThrombosisDue to Coronary Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. F. Williams M. D. Date signed 12/31/46
Address Cumberland

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 3 1947
BUREAU

1-35

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (752)

11604

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County... Allegany
City or town... ~~Bowmans~~ Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
~~22~~ Bowmans Addition, Rt. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Md. County... Allegany
City or town... ~~Bowmans~~ Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bowmans Addition, Rt. #3
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Tracky Lee Bobo

3. (b) Social Security Number

220-07-6676

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

6.(c) If alive, give age... years
T. Birth date of deceased (mo., day, yr.) March 16, 1917

8. AGE: Years 29 Months 8 Days 28 If less than one day hrs. min.

9. Birthplace Keyser, Mineral Co., W. Va.
(Town, county, and state)

10. Usual occupation Inspector of yarn

11. Industry or business Colozesa Corp. of America

FATHER 12. Name Gus Bobo

13. Birthplace Moorefield, W. Va.

MOTHER 14. Maiden name Elizabeth Spencer

15. Birthplace Keyser, W. Va.

18. Informant Manuel Bobo

Address Rt. 3, Cumberland, Md.

11. Burial Date thereof Dec. 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md.

18. Funeral director Phil G. Hoffer

Address Cumberland, Md.

11. Dec 17 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him Dead Dec. 14 1946

Immediate cause of death Fractured Skull and laceration of brain DURATION at once

Due to Accident.

Sawing slab wood, saw came loose

Due from framework & struck him

in the face and head.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-14-46

Where did injury occur? Bowmans Add. Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Circular saw came loose from framework & struck him in the face and head

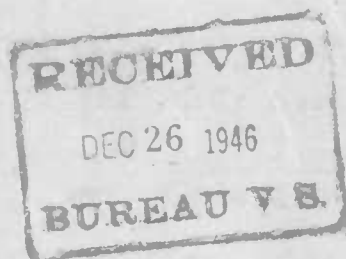
23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 12-14-1946

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-6

CERTIFICATE OF DEATH

Reg. Dist. No. 11605

1. PLACE OF DEATH:

County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No. Railroad St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Ann Brannon

3. (b) Social Security Number

none

4. Sex Female 5. Color of race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John Wm. Brannon

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 31, 1867

8. AGE: Years 79 Months 8 Days 19 If less than one day..... hrs. min.

9. Birthplace Mt. Savage, Allegany, Md.
(Town, city, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Patrick Farrell

13. Birthplace Ireland

14. Maiden name Catherine Gerrity

15. Birthplace Ireland

16. Informant James Brannon

Address Mt. Savage Md.

17. Burial (Burial, cremation, or removal) Which? Burial Date of Dec. 23 '46
(month) (day) (year)

Cemetery or crematory St. Patrick's

Location Mt. Savage Md.

18. Funeral director G.O. Dorist

Address Doristberg Md.

19. Dec 21 19 46 Virginia M. Dermott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1946 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Dec 1946

and that I last saw him alive on Dec 1946

Immediate cause of death Myocarditis DURATION Several days

Due to Mitral regurgitation

Due to vascular hypertension

Due to Atherosclerosis

Other conditions Intestinal obstruction

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE William E. Morley M.D. M. D. or other

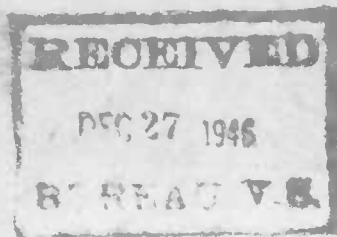
Address Mt. Savage Md. Date signed 12/20-1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

11606 40
Reg. Dist. No.

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 2 1/2 days
 Hospital, institution, or street address where death occurred... Memorial Hospital
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... md County... Allegany
 City or town... Locust Grove
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Railroad Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Daniel Calvin Brautnick

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Child

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 2, 1942

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

4428

hrs.

min.

9. Birthplace

Speculator, Hamilton Co. N.Y.
(Town, county, and state)

10. Usual occupation

Chief

11. Industry or business

FATHER

12. Name

Michael Brautnick

13. Birthplace

Harding, W. Va

MOTHER

14. Maiden name

Mae Huffman

15. Birthplace

Onego, W. Va

16. Informant

Michael Brautnick
Address Rt 6 Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof January 1, 1947
(month) (day) (year)

Cemetery or crematory

Huffman Cemetery

Location

Near Flintstone, Md.

18. Funeral director

Address

John J. Hoffer
Cumberland, Md.

19. Date rec'd by registrar

Dec 31, 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 19 46 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 19 46 to Dec 29 19 46and that I last saw him alive on Dec 29 19 46

Immediate cause of death

Acute Lymphatic Leukemia

DURATION

3 mks

Due to

Due to

Other conditions

Endocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin M.D.

M. D. or other

Address

Cumberland, Md.Date signed 12-30-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

BUREAU

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 956

CERTIFICATE OF DEATH

11607
40
Reg. Dist. No.

DR. W. F. WILLIAMS

1. PLACE OF DEATH:
County..... **ALLEGANY**
City or town..... **CUMBERLAND**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **MARYLAND** County..... **GARRETT**
City or town..... **FRIENDSVILLE**
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war..... ✓

3. (a) FULL NAME
MR. JACKSON CASTEEL

3. (b) Social Security Number
None

4. Sex
MALE
5. Color or race
WHITE
6. (a) Single, married, widowed, or divorced
MARRIED

6. (b) Name of husband or wife..... **KATHERINE (FRIEND) CASTEEL**

6. (c) If alive, give age..... **23** years
7. Birth date of deceased (mo., day, yr.)
SEPTEMBER 24, 1922

8. AGE:
Years..... **24** Months..... **2** Days..... **23**
If less than one day
..... hrs. min.

8. Birthplace..... **WEST VIRGINIA**
(Town, county, and state)
UNABLE TO WORK

10. Usual occupation.....

11. Industry or business.....

12. Name..... **OLIVER CASTEEL**

13. Birthplace..... **WEST VIRGINIA**

14. Maiden name..... **LAURA RECHART**

15. Birthplace..... **MARYLAND**

16. Informant..... **Memorial Hosp.**
Address..... **Cumberland, Md.**

17. Burial (Burial, cremation, or removal, Which?) Date thereof..... **Dec. 19, 1946**
(month) (day) (year)
Cemetery or crematory..... **Blossoming Rose Cem.**
Location..... **Near Friendsville, Md.**

18. Funeral director..... **H. H. Davis**
Address..... **Friendsville, Md.**

19. **Dec. 17, 1946** J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION I; 20 A.M.

20. DATE OF DEATH..... **DECEMBER 17, 1946**..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12:15..... 19..... **46** to..... **12:17**..... 19..... **46**
and that I last saw him/her alive on..... **12:17**..... 19..... **46**

Immediate cause of death..... **Chronic Rheumatic Heart Disease**

Due to.....

Due to.....

Other conditions..... **No**

(Include pregnancy within 8 months of death)

Major findings of operations..... **None**
Date of op..... **None**

Autopsy results..... **None**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE..... **Wm. F. Williams**
M. D. or other

Address..... **Cumberland** Date signed..... **12:17:46**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 26 1946

BUREAU V.R.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

CERTIFICATE OF DEATH

11608 40

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77-11-2
Hospital, institution, or street address where death occurred:
Allegany Hospital, Cumberland, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 329 Fayette St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Miss Mattie Caton — Martha Agnes Caton.

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 22 1869

8. AGE: Years 77 Months 11 Days 2 If less than one day
hrs. min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation Registered Nurse

11. Industry or business

12. Name Robert Caton

13. Birthplace Ireland

14. Maiden name Mrs. M. M. M.

15. Birthplace Ireland

16. Informant Anna C. Caton

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 27 46
(month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem.

Location Cumberland

18. Funeral director Dom's Stein Inc

Address Cumberland

19. Dec 26 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 19 46 at 5:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22 46 to 12 24 46
and that I last saw him alive on 12 24 46

Immediate cause of death Myocarditis DURATION 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Johnson M.D. M. D. or Other

Address Cumberland Md Date signed 12-26-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IDENTIFICATION

RECEIVED

JAN 2 1947

BUREAU VS

2-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

11609

CERTIFICATE OF DEATH



Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

Allegheny Hospital
How long in hospital or institution? 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 144 Stanover St.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Rachael Cioni

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Valentino Cioni

7. Birth date of

deceased (mo., day, yr.)

July 12 1878

6. (c) If alive, give age _____ years

8. AGE:

Year

Months

Days

If less than one day

68429

hrs.

min.

9. Birthplace

(Town, county, and state)

Italy

10. Usual occupation

Housewife

11. Industry or business

at Home

FATHER

12. Name

Carmen Mancinella

13. Birthplace

Italy

MOTHER

14. Maiden name

Caroline Tassola

15. Birthplace

Italy

16. Informant

Anthony Cioni

Address

Cumberland17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

Dec. 13 46
(month) (day) (year)

Cemetery or crematory

St. Patrick's Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc.

Address

Cumberland19. Dec. 18 46

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 19 46, at 12:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-26-46 19 46, to 11 Dec. 19 46.and that I last saw him alive on 10 Dec. 46 19 46.

Immediate cause of death

1. Chronic nephritis ?2. Hypertensive heart disease ?Due to 3. General bronchial pneumonia 5 da4. Renal uraemia 3 weeks

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

W. A. Van Dusen
1105. Cent St. M. D. or other
Address _____ Date signed 11 Dec 46

RECEIVED

DEC 18 1946

BGP 13

2-35

Within corporate limits *Wm*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *212*

11610

CERTIFICATE OF DEATH

Reg. Dist. No. *40*

1. PLACE OF DEATH:

County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hrs. 15 min. 52 years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? CUMBERLAND, MD. 8 hrs. 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MD. County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 204 PENNA. AVE.
(If rural, give LOCATION)
2. (a) If veteran, name war...

3. (a) FULL NAME

COAKLEY, EDWIN R.

3. (b) Social Security Number

705-09-9360

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife KIRTLY, VIOLA
6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 3-2-1894

8. AGE: Years 52 Months 9 Days 9 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation PIPE FITTER FOREMAN B&O

11. Industry or business B & O R R

12. Name COAKLEY, JAMES WM.

13. Birthplace Cumberland, Md

14. Maiden name STEINBAUGH, PAULINE

15. Birthplace Bedford, Pa.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof December 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director Phy J. H. H. H.

Address Cumberland, Md.

19. Dec 14 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. W.F. WMS.

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 11, 19 46 at 9:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12. 11. 1946 to 12. 11. 1946 and that I last saw him alive on 12. 11. 1946

Immediate cause of death Cerebral Hemorrhage
DURATION 9 hrs.
Due to Cerebral Hemorrhage
Due to Cerebral Hemorrhage
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of None
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W.F. Williams M.D. or other
Address Cumberland Date signed 12.12.46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-70)

11611

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town 610 Green St. Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

610 Greene Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town 610 Green St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 610 Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James H. Cook

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Martha Duffy Cook

7. Birth date of

deceased (mo., day, yr.)

Aug. 8, 1863

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

83422

hrs.

min.

9. Birthplace

Frostburg, Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Court House Attache

FATHER

12. Name

John Cook

13. Birthplace

London England

MOTHER

14. Maiden name

Bettie Pewter

15. Birthplace

Germany

16. Informant

Mrs. Alvin R. Serf Sr.Address 610 Greene St. Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 1, 1947

(month) (day) (year)

Cemetery or crematory

Rose Hill Mausoleum

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19. Jan 1, 47

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 19 46 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him Dead Dec. 30 19 46

Immediate cause of death

Intercranial hemorrhage & fractured skull

DURATION

at onceDue to a bullet wound through skullDue to suicide

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 12.30.1946Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury 32 caliber revolverDeputy Medical Examiner: Allegany23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. ofAddress Cumberland Md. Date signed 12.30/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

BUREAU V S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (154)

CERTIFICATE OF DEATH

Reg. Dist. No. 11612 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, Md.How long in hospital or institution? 8 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 513 Beall St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Cooper

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/27/468. AGE: Years Months Days If less than one day
8 hrs. min.9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Keith Cooper13. Birthplace Cumberland, Maryland14. Maiden name Verna Hager15. Birthplace Cumberland, Maryland16. Informant Mr. Keith CooperAddress 513 Beall St. Cumberland, Md.17. Burial Date thereof Dec. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S. S. Peter & PaulLocation Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Dec. 28 19 46 J. C. Peaslee
(Date rec'd by registrar) M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 19 46 at 4:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/27 19 46 to 12/27 19 46and that I last saw him alive on 12/27 19 46Immediate cause of death Prematurity DURATION 2 daysDue to (?)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M. D. or otherAddress 41 Greenfield Date signed Dec. 28, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The perfect age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1947

BUREAU VS

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-1

CERTIFICATE OF DEATH

Reg. Dist. No. 11613 40

1. PLACE OF BIRTH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

509 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 509 Greene St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louanna Cooper

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Wm Benton Cooper

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Dec 74 18778. AGE: Years 68 Months 11 Days 19 If less than one day
..... hrs. min.9. Birthplace Morefield W. Va.
(Town, county, and state)10. Usual occupation Housewife at home

11. Industry or business

12. Name Louis Willis13. Birthplace W. Va.14. Maiden name Emma Walker15. Birthplace W. Va.16. Informant Miss Matthe CooperAddress Cumberland17. Burial Date thereof Dec 16 46
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland18. Funeral director Louis Stein, Inc.Address Cumberland19. Dec 16 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1946 at 7 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Dec 13 1946and that I last saw him alive on Aug 17 1946Immediate cause of death Coronary Thrombosis DURATION 10 minutesDue to Hypertension & Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler, M.D. M. D. or otherAddress 41 Greene St. Date signed Dec 17 46

RECEIVED

DEC 19 1946

2A - 8

1-35

Wm Schindler

Elizabeth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 11614 40

1. PLACE OF DEATH:

County Allegany County
 City or town Gettysburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
764 Maryland Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 764 Maryland Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mrs Norma Danton Cuppsett

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Commodore W. Cuppsett

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1867

8. AGE: Years 79 Months 10 Days 19 hrs. min.

9. Birthplace Sugar Valley W. Va
(Town, county, and state)10. Usual occupation Housework11. Industry or business at home12. Name Henry E. Cale13. Birthplace W. Va14. Maiden name Sarah Feather15. Birthplace Valley Point W. Va16. Informant Mrs E. B. BurnerAddress 764 2nd Ave Cumb. Md17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof Dec 20, 1946
(month) (day) (year)Cemetery or crematory Terra Alta CemeteryLocation Terra Alta W. Va18. Funeral director John J. HoferAddress Cumberland, Md19. Dec 18, 1946 J. P. Tankli, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17, 1946 at 4:55 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 43 to Dec 17 1946
and that I last saw him alive on Dec 16 1946Immediate cause of death Heart failure DURATIONDue to coronary arteriosclerosisDue to heart diseaseOther conditions old agesenile arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nathaniel Brown M.D. M. D. or otherAddress Camp, Md. Date signed 12/18/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 26 1946

BUREAU V B.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week
 Hospital, institution, or street address where death occurred:
Kolbergs Hill
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Christina Cutter

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Charles Cutter 6. (c) If alive, give age. years
 7. Birth date of deceased (mo., day, yr.) February 6, 1867
 8. AGE: Years 79 Months 10 Days 22 If less than one day
 hrs. min.

9. Birthplace Yorkshire, Scotland
 (Town, county, and state)
 10. Usual occupation Domestic
 11. Industry or business own home
 FATHER 12. Name James Walker
 13. Birthplace Scotland
 MOTHER 14. Maiden name Agnes Thompson
 15. Birthplace Scotland

16. Informant Mrs Walter Whitfield
 Address Westernport, Maryland
 17. burial Date thereof Dec 31, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Philos Cemetery
 Location Westernport, Maryland
 18. Funeral director Ellsworth S. Roal
 Address 111 Church St. Westernport, Md.
 19. Dec. 31 19 1946
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 19 46 at 7:15 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12/27/46 19 to 12/28 19
 and that I last saw him alive on 12/28/46 19

Immediate cause of death Cornary Thrombosis DURATION 2 days

Due to
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE [Signature] M. D. or other
 Address [Signature] Date signed 12/29/46

RECEIVED

JAN 2 1947

BUREAU V B

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

11616

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Allegany
City or town about 1/2 mile west of McCoole Md
route 36
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Mineral
City or town Piedmont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 87 Erin
(If rural, give LOCATION)
2. (a) If veteran, name war World War # 2

3. (a) FULL NAME Lewis DANCER
Robert Lewis Dancer

3. (b) Social Security Number
220-10-1409

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mabel Alkire Dancer
6. (c) If alive, give age 26 years
7. Birth date of deceased (mo., day, yr.) July 23, 1919

8. AGE: Years 27 Months 4 Days 12 hrs. min.

9. Birthplace Piedmont, Mineral, W. Va.
(Town, county, and state)

10. Usual occupation Clerk
11. Industry or business W. Va. Pulp and Paper Co.

12. Name William C. Dancer
13. Birthplace Grafton, W. Va.

14. Maiden name Edna Swann
15. Birthplace Bloomington, Maryland

16. Informant Mr. Fay Plaughter
Address Westernport, Maryland

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 7, 1946
(month) (day) (year)
Cemetery or crematory Philos Cemetery
Westernport, Md.
Location Ellsworth S. Doal

18. Funeral director Ellsworth S. Doal
Address Westernport, Maryland

19. Dec. 7 19 46 Registrar George M. Barber MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 19 46 12.25AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him Dead Dec. 5 19 46

Immediate cause of death Crushed skull and fractured vertebrae of the neck DURATION at once

Due to Fractured jaw and left forearm.

Other conditions Fractured jaw and left forearm.
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 12.5.1946
1/2 Mi. west of McCoole Md.
Where did injury occur? Route 36 (County) Allegany (State)

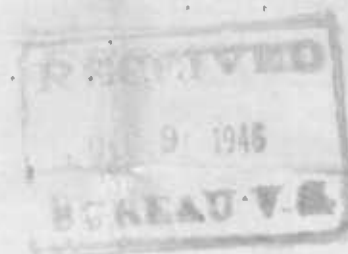
Injured at home, farm, industry, public place (where?) Route 36
Means of injury Automobile accident at work?

23. SIGNATURE H.V. Deming M.D. H. V. Deming MD
M. D. or other
Address Cumberland Md Date signed 12.5.46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-7

CERTIFICATE OF DEATH

Reg. Dist. No. 11617 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

125 West Third Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 125 West 3rd St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Ann Davies

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife William Davies

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) May 25, 18518. AGE: Years Months Days It less than one day
95 6 20 hrs. min.9. Birthplace Swansea, Wales
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. Gomer DaviesAddress 125 W. 3rd St. Cumberland, Md.17. Burial Date thereof Dec. 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Dec 17 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec. 15, 19 46, at 3:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1946, to Dec. 15, 1946, and that I last saw him alive on Dec. 15, 1946Immediate cause of death Arteriosclerosis
Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

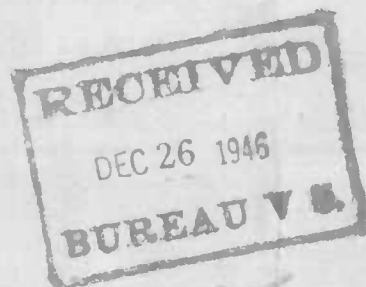
23. SIGNATURE J. P. Franklin M. D. or otherAddress Cumberland Date signed 12/16/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

11618
20
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Flintstone (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 46 years
 Hospital, institution, or street address where death occurred:
Star route
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Flintstone (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Star route
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Frank Benjamin Davis

3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Carrie M. Davis

7. Birth date of deceased (mo., day, yr.)

Nov. 1, 1862

6. (c) It alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

8416

hrs.

min.

9. Birthplace

Cambria County, Pa.
(Town, county, and state)

10. Usual occupation

Saw mill man

11. Industry or business

Own mill

12. Name

David L. Davis

13. Birthplace

unknown

14. Maiden name

Nancy J. Kelly

15. Birthplace

Funkhouser Co., Pa.

16. Informant

Walter L. Davis

Address

Flintstone Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 10, 1946

(month) (day) (year)

Cemetery or crematory

Old Fellows cemetery

Location

Flintstone Md.

18. Funeral director

Ephraim Smith

Address

Artemus, Pa.19. Dec. 9, 1946
(Date rec'd by registrar)Nina L. Bender
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1946 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10, 1946 to Dec. 7, 1946
and that I last saw him alive on December 7, 1946

Immediate cause of death

Cardiovascular collapse

DURATION

5 days

Due to

Due to

Other conditions

Senile gangrene
Foot amputated five months ago
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

J. A. Watson M.D.
Little Orleans Md.
M. D. or other _____
Date signed 12/8/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

MEDICAL CERTIFICATE

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DEC 12 1946

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-1-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURA and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred: Miners Hospital
 How long in hospital or institution? 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURA and give nearest town)
 Street No. 62 Spring St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Grace Elizabeth Davis

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 6.(c) If alive, give age. years
 7. Birth date of deceased (mo., day, yr.) August 30 1889

8. AGE: 57 Years 3 Months 24 Days (If less than one day)
 hrs. min.

9. Birthplace Frostburg, Allegany Cty., Md.
 (Town, county, and state)

10. Usual occupation home

11. Industry or business

12. Name John R. Davis

13. Birthplace Maryland

14. Maiden name Mary A. House

15. Birthplace Maryland

16. Informant Sam Davis

Address Frostburg, Md.

17. Burial, cremation, or removal (Which) Burial Date hereof Dec. 27 1946
 (month) (day) (year)

Cemetery or crematory Allegany
 Location Frostburg, Md.
 18. Funeral director Querst
 Address Frostburg, Md.

19. 12-27 46 Mrs. Nancy N. Doe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1946 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1946 to Dec 25 1946
 and that I last saw him alive on Dec 25 1946

Immediate cause of death

Cerebral Apoplexy DURATION 12 hrs.

Due to C-V-Renal disease 2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N E Lattens M D, or other

Address Frostburg, Md. Date signed 12/26/46

Handwritten notes, mostly illegible due to blurring and bleed-through.

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DEC 30 1946
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Handwritten notes at the bottom of the page, including the word "checked" and other illegible text.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *FD*

CERTIFICATE OF DEATH

11620

Reg. Dist. No. *140*

1. PLACE OF DEATH:

County *Allegany*City or town *Corryville*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Route 36 RFD #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Allegany*City or town *Corryville*
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Elmer Ellsworth Dickenbaugh

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Agnes Dean

7. Birth date of

deceased (mo., day, yr.)

Aug 11 1866

8. AGE:

Years

Months

Days

If less than one day

*80**4**6*

hrs.

min.

9. Birthplace

Int. Damage Ind.
(Town, county, and state)

10. Usual occupation

Road Foreman

11. Industry or business

C & P Ry

FATHER

12. Name

Sylvester Dickenbaugh

13. Birthplace

Ind.

MOTHER

14. Maiden name

Elizabeth Slider

15. Birthplace

Ind.

16. Informant

Mrs. E. E. Dickenbaugh

Address

Corryville Ind.

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

12 20 46
(month) (day) (year)

Cemetery or crematory

Greenmount Cem.

Location

Cumtland

18. Funeral director

Amis Stein Inc.

Address

Cumtland

19. Date rec'd by registrar

*Dec 19 46**Dec 21 1946*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 17 46* at *9:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/9/46 to *12/17/46*and that I last saw him alive on *12/17/46*

Immediate cause of death

Chronic myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE

*John W. Rogers M.D.*Address *Cumtland* Date signed *12/18/46*

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H. H. A. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

11621

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Sylvan Retreat, Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 2 1/2 months

Hospital, institution, or street address where death occurred
Valley Road - Sylvan Retreat

How long in hospital or institution? about 2 1/2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Grahamtown
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Harrison Duckworth

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Mary Lavine Duckworth

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1855

8. AGE: Years 91 Months 8 Days 1 If less than one day
 hrs. min.

9. Birthplace Barton, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation retired11. Industry or business woodsman

FATHER 12. Name William Duckworth,

13. Birthplace Maryland

MOTHER 14. Maiden name Catherine Murphy,

15. Birthplace Maryland

16. Informant Simeon Duckworth,
 Address Frostburg, Md.

17. Burial Date thereof Dec. 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Vale Summit,Location Vale Summit, Md.18. Funeral director J. J. Durst,Address Frostburg, Md.

19. Dec 5, 46 J. P. Faulkner, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1946 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....

and that I last saw him alive on Dec. 5, 1946

Immediate cause of death.....

General Arterio sclerosis DURATION Several
years

Due to Senility

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming
 M. D. or other

Address Cumberland Md. Date signed 12.5.46

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 10 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11622

Reg. Dist. No.

40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 902 Hill Top Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Minerva Eshleman

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Samuel Eshleman7. Birth date of deceased (mo., day, yr.) Feb. 11, 1870

6. (c) If alive, give age

8. AGE: Years Months Days It less than one day

76 10 9 hrs. min.8. Birthplace Maytown, Lancaster, Penna.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name William Fisher13. Birthplace Maytown, Penna.14. Maiden name Charlotte Knollman15. Birthplace Maytown, Penna16. Informant Mr. Victor HeiseyAddress 902 Hill Top Drive, Cumberland, Md17. Burial Date thereof Dec 23, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Joy CemeteryLocation Mt. Joy, Penna.18. Funeral director John J. HaterAddress Cumberland, Md.19. Dec. 20 19 46 Joseph P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 19 46 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 28 19 46 to Dec 20 19 46and that I last saw him alive on Dec 20 19 46

Immediate cause of death

Cerebral Hemorrhage with Psychoses 3 wks

Due to

Due to

Other conditions Diabetes mellitus 20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

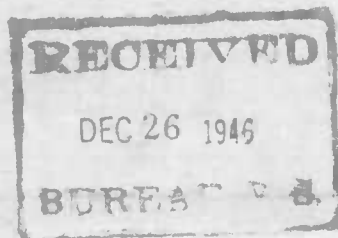
Means of Injury Injured at work?

23. SIGNATURE C. L. Owens, M.D.Address Brown Island, Md Date signed 12-20-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11623

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 hours
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 65 Bowery St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

MARY THOMAS EVANS

3. (b) Social Security Number
none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Daniel Evans
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) November 18, 1890
 8. AGE: Years 56 Months 0 Days 23 If less than one day
 hrs. min.

9. Birthplace Frostburg, Allegany, Maryland
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business home

FATHER 12. Name Charles Thomas
 13. Birthplace Wales
 MOTHER 14. Maiden name Emily Whitney
 15. Birthplace Pennsylvania

16. Informant Daniel Evans
 Address Frostburg, Md.

17. Burial Date thereof Dec. 15, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Allegany
 Location Frostburg, Md.

18. Funeral director J. J. Durst
 Address Frostburg, Md.

19. Dec 13 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1946 at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 P.M. to 11:55 P.M. on 11 Dec. 1946
 and that I last saw him alive on 11 Dec. 46 1946

Immediate cause of death Cerebral thrombosis
diabetes mellitus
 Due to 6 days
6 yrs
 Due to 6 yrs
 Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. T. R. R. R. R. R.
110 S. B. St. M. D. or other Combed, 2d.Address 110 S. B. St. Date signed 13 Dec. 46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1220)

11624

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital 215 Decatur Street

How long in hospital or institution?

11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town 213 Bedford Street, Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. John Mills Felmlee

3. (b) Social Security Number

214-05-8104

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mrs. Marie Felmlee

7. Birth date of deceased (mo., day, yr.)

December 25, 18876. (c) If alive, give age 51 years

8. AGE:

Years 59
60Months 0Days 0

If less than one day

hrs. _____ min. _____

9. Birthplace

Pennsylvania Lewistown
(Town, county, and state)

10. Usual occupation

Store Manager

11. Industry or business

Acme Furniture Co.

FATHER

12. Name

John (Dec.) Felmlee

13. Birthplace

Lewistown, Pa.

MOTHER

14. Maiden name

Mary Zimmerman (Dec.)

15. Birthplace

Lewistown, Pa.

16. Informant

Mrs. Marie Brant FelmleeAddress 213 Bedford St. Cumberland, Md.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof Dec. 28, 1946
(month) (day) (year)

Cemetery or crematory

Trinity Luthern Cemetery

Location

Cumberland, Maryland

18. Funeral director

William H. Kight

Address

Cumberland, Maryland

19.

Dec. 27, 1946
(Date rec'd by registrar)J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1946, at 6:17 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/14, 1946, to 12/25, 1946
and that I last saw him alive on 12/25/46

Immediate cause of death

Strangulated hernia

DURATION

Due to _____

Due to _____

Other conditions

bronchitis
bronchovascular

(Include pregnancy within 3 months of death)

Major findings of operations

Strangulated hernia
Date of op. 12/14/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

John P. Franklin, M.D.
Address Cumberland, Md. Date signed 12/26/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. W.F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11625/40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 408 Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Philip A. Fetzer

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 10, 1872

6.(c) If alive, give age..... years

8. AGE:

74

Years

Months

10

Days

6

If less than one day

..... hrs.

..... min.

9. Birthplace West Virginia

(Town, county, and state)

10. Usual occupation Caretaker

11. Industry or business

FATHER

12. Name John Fetzer13. Birthplace Virginia

MOTHER

14. Maiden name Catherine Everly15. Birthplace Virginia16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Dec. 19, 1946
(month) (day) (year)Cemetery or crematory Moorefield Cem.Location Moorefield, W. Va.

18. Funeral director

Charles L. George

Address

Cumberland, Md.19. Dec. 19, 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1946, at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

11.28.1946 to Dec. 16, 1946
and that I last saw him alive on 12.16.1946

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland Date signed 12.17.46

RECEIVED
DEC 26 1946
BUREAU V &
2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs
 Hospital, institution, or street address where death occurred
14 Hillison Place
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 14 Hillison Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Emma L Fox

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ervin Fox
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) November 6 1895
 8. AGE: Year 51 Months 1 Days 5 If less than one day..... hrs. min.

9. Birthplace Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Turner L. Risher13. Birthplace Va.MOTHER 14. Maiden name Marietta Hahne15. Birthplace Va.16. Informant Mrs Etta WilsonAddress Cumberland17. Burial Date thereof Dec 14 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenview Cem.Location Cumberland Md18. Funeral director Lois SteinAddress Cumberland19. Dec. 13 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 19 46 at 9:30 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to December 11 19 46; and that I last saw her alive on December 11 19 46.Immediate cause of death Cerebral Hemorrhage
Chronic Hypertension
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

DURATION

2 hours
1 year

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE J. P. Franklin, M.D.Address Cumberland Md M. D. or otherDate signed 12-12-46

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DEC 18 1946

BUREAU

11-38-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 11627/40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 75 years
 Hospital, institution, or street address where death occurred:
501 Maryland Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 501 Maryland Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Elias Gatehouse

3. (b) Social Security Number

220-10-0146

4. Sex 5. Color or race 6. (a) Single, married, or divorced

male white married

6. (b) Name of husband or wife Annie Bradley6. (c) If alive, give age 76 years7. Birth date of deceased (mo., day, yr.) November 29, 18718. AGE: Years Months Days It less than one day
75 0 18 hrs. min.9. Birthplace Frostburg, Allegany Co., Md.
(Town, county and state)10. Usual occupation Retired Machinist11. Industry or business Cumberland Steel Co.12. Name Thomas Gatehouse13. Birthplace Wales14. Maiden name Sarah Jane Tonkins15. Birthplace Wales16. Informant Mrs. Elias GatehouseAddress 501 Maryland Ave., Cumberland, Md.17. Burial Date thereof December 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg, Md.18. Funeral director John J. H. H.Address Cumberland, Md.19. Dec. 19, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 19 46 at 12.30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him Dead Dec. 17 19 46Immediate cause of death Coronary occlusion DURATION at once
Due to Arterio-sclerosis several
Due to yearsOther conditions
(Include pregnancy within 3 months of death)Major findings of operations
Date of op.Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

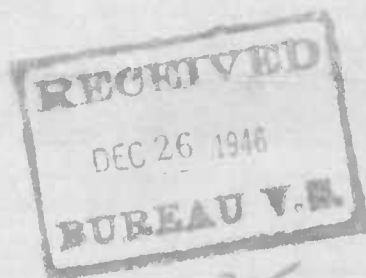
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland Md. Date signed Dec. 17, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9370

1454 CERTIFICATE OF DEATH



11628

Reg. Dist. No.

40

1. PLACE OF DEATH:

County Allegany
Cumberland
City or town 40 Years
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany County Infirmary
How long in hospital or institution? 8 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 223 Davidson St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Speros P. Giatras

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1887

8. AGE: Years 59 Months 6 Days 28 If less than one day hrs. min.

9. Birthplace Sparta, Greece
(Town, county, and state)

10. Usual occupation Candy Maker

11. Industry or business Candy Store

12. Name Panagitis D. Giatras

13. Birthplace Sparta, Greece

14. Maiden name Anna Cachulis

15. Birthplace Sparta, Greece

16. Informant George P. Giatras

Address 223 Davidson St., Cumberland, Md.

17. Burial Date thereof 12/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Dec 16 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 19 46, at 7-15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 19 46 to Dec 14 19 46
and that I last saw alive on Dec 13 19 46

Immediate cause of death Myocardial failure

Due to Chronic myocarditis

Due to Chronic Asthma

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

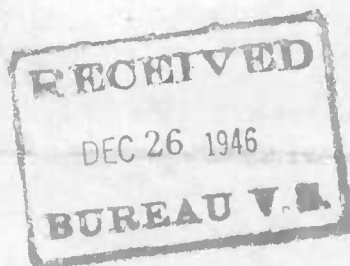
23. SIGNATURE Arthur P. Jones M.D. M. D. or other

Address 110 S. Centre St. Date signed 12-14-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

2411 N. Charles St., Baltimore *R36*

CERTIFICATE OF DEATH

Reg. Dist. No. *40*

1. PLACE OF DEATH:

County *Alleghany*
 City or town *Cumberland, Maryland*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *11 days*
 Hospital, institution or place of death *Alleghany Hospital*
215 Decatur Street
 How long in hospital or institution? *11 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *Maryland* County *Alleghany*
 City or town *Cumberland*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *417 Pine Place*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Mrs. Mollie Giles

3.(b) Social Security Number

None

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
 6.(b) Name of husband or wife *Bernard Giles*
 7. Birth date of deceased (mo., day, yr.) *4/5/84* 6.(c) If alive, give age years
 8. AGE: Years *62* Months *7* Days *18* If less than one day hrs. min.

9. Birthplace *Maryland*
 (Town, county, and state)
 10. Usual occupation *Housewife*
 11. Industry or business

FATHER 12. Name *Perry Deetz (Dec.)*
 13. Birthplace *MD.*
 MOTHER 14. Maiden name *Jane Cessna (Dec.)*
 15. Birthplace *MD.*

16. Informant *Bernard L. Giles*
 Address *Cumberland*
 17. *Burial* Date thereof *Dec 21 '46*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *Green Grove Park*
 Location *Cumberland*
 18. Funeral director *Louis Stein Inc*
 Address *Cumberland*
Dec 21 1946 Registrar *J.P. Franklin MD*
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *18 Dec. 46* 19..... at *5:05 P.* M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *7 Dec. 46* 19..... to *18 Dec.* 19.....
 and that I last saw him alive on *18 Dec. 46* 19.....

Immediate cause of death *Cerebral Thrombosis with its Complications.* DURATION *2 wks*
 Due to *General Blood Pressure* *1 wk*
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE *W. Alfred Van Dusen* M. D. or other
 Address *110 S. Centre St* Date signed *20 Dec 46*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 26 1946

BUREAU OF

1-35

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

11630

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
Allegany Grove
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Allegany Grove
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ethel E Gilkey

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Orval Gilkey
7. Birth date of deceased (mo., day, yr.) June 20 1899 6.(c) If alive, give age. years
8. AGE: Years 47 Months 6 Days 5 If less than one day hrs. min.

9. Birthplace Charlottesville Va.
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business at home

12. Name French Grant

13. Birthplace Va.

14. Maiden name Mary E Wood

15. Birthplace Va.

16. Informant John M Gilkey

Address La Vale Md

17. Burial Date thereof Dec 28 46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Dec. 27 19 46 J.P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 19 46 at 10:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 46 to Dec 25 19 46

and that I last saw him alive on December 25 19 46

Immediate cause of death

apoplexy

Due to asthma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter MD M. D. or other
Address Cumberland Md Date signed 12/26/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1947

BUREAU V B

1-35

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Seventeen days
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? Seventeen days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 418 Springdale Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Gray *2nd twin*
 4. Sex Male 5. Color of race White 6.(a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 19 46, at 8:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-19- 19 46, to 12-6- 19 46,
 and that I last saw him alive on 12-6- 19 46

Immediate cause of death premature baby
 DURATION

Due to twins birth

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Franklin MD M. D. or otherAddress 59 Green St Date signed 12-6-46

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 19, 19468. AGE: Years Months Days It less than one day
0 0 17 hrs. min.9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name George Gray13. Birthplace Maryland14. Maiden name Juanita Roby15. Birthplace Maryland16. Informant Allegany HospitalAddress 215 Decatur Street17. Burial Date thereof Dec. 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Robey Cemetery (Family)Location Near Little Orleans Md.18. Funeral director Charles L. GeorgeAddress Cumberland Md.19. 12/6/46 19 46
(Date rec'd by registrar) Registrar J. B. Franklin MD

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 10 1946

BUREAU V S

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11632

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 10 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 55 Greene Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas T. Gray

3. (b) Social Security Number

218-16-2831

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1887

8. AGE: Years 59 Months 8 Days 23 If less than one day
.....hrs.min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business Potomac Edison Co.

12. Name Thomas Gray

13. Birthplace Md.

14. Maiden name Lettie Cheney

15. Birthplace Md.

16. Informant Allegany Hospital

Address 215 Decatur Street

17. Burial Date thereof Dec. 30, 1946
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory St. Patrick's Cem.

Location Cumberland, Md.

18. Funeral director Charles T. George

Address Cumberland, Md.

19. Dec. 21, 46 Registrar J. P. Franklin
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 A.M. 26 Dec. to 10 A.M. 29 Dec. and that I last saw him alive on 26 Dec 46

Immediate cause of death Cerebral Hemorrhage DURATION 1 1/2 hours

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Cerebral Hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. V. in M. D. or other

Address 1103 Center St Date signed 28 Dec

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 2 1947
BUREAU V S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11665

Reg. Dist. No. 90

1. PLACE OF DEATH

County AlleganyCity or town Frankfort
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

68 Linden St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County AlleganyCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)Street No. 135 Massachusetts Dr
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Christina Wandel

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

723 mos28

hrs.

min.

8. Birthplace

Cumtland Alleg. Ind.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1-2-1947
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

18.

47 W. Xaver N. Roe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 30 1946 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 16 1946 to Dec 29 1946and that I last saw her alive on Dec 29 1946

Immediate cause of death

Chr. Myocarditis

DURATION

6 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1-2-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

BUREAU

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

11633

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 702 FREDERICK ST.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY BOY HANSEL William Byron Hansel

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

INFANT

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) DEC. 9, 1946

8. AGE:

Years

Months

Days

If less than one day

13

hrs.

24

min.

9. Birthplace

CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name

OLIVER HANSEL

13. Birthplace

MD.

MOTHER

14. Maiden name

JUNE PEEBLES

15. Birthplace

MD.

18. Informant

Oliver Hansel

Address

702 Frederick St, Cumberland, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

December 13, 1946
(month) (day) (year)

Cemetery or crematory

St. Luke's Lutheran Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hoffman

Address

Cumberland, Md.

19.

Dec. 12, 1946

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 11 19 46, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 9/46 19 to Dec 11/46 19and that I last saw him alive on Dec 11/46 19

Immediate cause of death

Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ernest Reynolds, M.D.

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

BUREAU

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

11634 40
Reg. Diat. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

135 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 135 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frances Rosalie Harvey

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Harry Harvey7. Birth date of deceased (mo., day, yr.) November 29, 1910
6.(c) If alive, give age years8. AGE: Years Months Days It less than one day
36 0 5 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name William Thomas13. Birthplace Frostburg, Maryland14. Maiden name Nancy Bell Hackman15. Birthplace Frostburg, Maryland16. Informant Mrs. Truman FullerAddress 422 Baltimore Ave., Cumberland, Md.17. Burial Date thereof December 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director John J. HooperAddress Cumberland, Md.19. Dec 6 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 19 46 at 9 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 46 to 19 46
and that I last saw him er Dead Dec. 4 19 46Immediate cause of death
Coronary sclerosis and
insufficiency
Due to Alcoholism
Other conditionsDURATION
at
once
several
years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Cumberland, Md. Date signed 12-5-1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 10 1946

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

Dr Wolverton, Jr

CERTIFICATE OF DEATH

 ★ 1163560
 Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 years
 Hospital, institution, or street address where death occurred:
310 Pratt St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 310 Pratt St
 (If rural, give LOCATION)
 2.(c) If veteran, name war

3. (a) FULL NAME

Irene Harvey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Harley W. Harvey
 6. (c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) March 16, 1892

8. AGE: Years 54 Months 9 Days 15 If less than one day
 hrs. min.

9. Birthplace Elk Garden, Mineral, W. Va.
 (Town, county, and state)

10. Usual occupation domestic

11. Industry or business own home

FATHER 12. Name Philmore White

13. Birthplace Elk Garden, W. Va.

MOTHER 14. Maiden name Elizabeth Ross

15. Birthplace Lonaconing, Maryland

16. Informant Mr Harley W. Harvey

Address 310 Pratt St, Luke, Md.

17. Burial Date thereof 2 Jan 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. Jan 2 1947
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1946 at 3:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1946 to December 31 1946
 and that I last saw her alive on Dec 15 1946

Immediate cause of death Cerebral hemorrhage DURATION 15 min

Due to Hypertensive cardiovascular disease 5 yrs

Due to

Other conditions Diabetes mellitus 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE James Wolverton Jr M.D. M. D. or other

Address Piedmont W. Va. Date signed Jan 2, 1947

RECEIVED

JAN 3 1947

RECEIVED

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

11636

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town 19 Harrison St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cresap Park
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert S. Harvey

3. (b) Social Security Number

220-10-4168

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Catherine Jordine7. Birth date of deceased (mo., day, yr.) January 25, 1869 6. (c) If alive, give age 76 years8. AGE: Years Months Days If less than one day
77 10 12 _____ hrs. _____ min.9. Birthplace Scotland
(Town, county, and state)10. Usual occupation Retired11. Industry or business Coal Mines12. Name Robert S. Harvey13. Birthplace Scotland14. Maiden name Mary Gibson15. Birthplace Scotland16. Informant John HarveyAddress 716 C St. N.E. Washington, D.C.17. Burial Date thereof December 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Franklin, Md.18. Funeral director John J. HarperAddress Cumberland, Md.19. Dec 9 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1946 at 1:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____, and that I last saw him Dead Dec. 7 1946Immediate cause of death
Coronary occlusion DURATION
at
onceDue to Arterio-sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other _____Address Cumberland Md. Date signed 12-9-1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

11637

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleganyCity or town 50 N. Center St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 66 yrs

Hospital, institution, or street address where death occurred

50 N. Center St.How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 50 N. Center St.
(If rural, give LOCATION)2.(a) If veteran, name war

3. (a) FULL NAME

Rosa Beckman HAYDEN

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband HILFEARY HAYDEN6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) June 7, 18808. AGE: Years 66 Months 6 Days 26 If less than one day hrs. min.9. Birthplace Cumberland Ind.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Erikas Beckman13. Birthplace Ind.14. Maiden name Catherine Greister15. Birthplace Ind.16. Informant Walter BeckmanAddress Cumberland17. Burial Date thereof Dec 31 46
(Burial, cremation, or removal. Which?) (month) (day), (year)Cemetery or crematory Trinity Lutheran Cem.Location Cumberland18. Funeral director Long & Son Inc.Address Cumberland19. Dec 31 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 19 46 about 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

 19 to 19 and that I last saw h. er Dead Dec. 29 19 46

Immediate cause of death

Myocarditis

DURATION

severalmonths.Due to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? Deputy Medical Examiner Allegany23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other Address Cumberland Md. Date signed 12/30/46

RECEIVED

JAN 3 1947

BUREAU V. C.

1-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99-2

CERTIFICATE OF DEATH



Reg. Dist. No.

116389

1. PLACE OF DEATH:

County alleganyCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.

136 Center St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County alleganyCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 136 center
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Wm Leslie Hendley

3. (b) Social Security Number

213-05-7155

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced -

married

6. (b) Name of husband or wife

Juanita Hendley6. (c) If alive, give age 42 years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

46 Years4 Months22 Days

It less than one day

hrs.

min.

9. Birthplace

Smithsburg - alleg - md.
(Town, county, and state)

10. Usual occupation

Bus driver

11. Industry or business

C. & W. Transit Co.

12. Name

John Wm. Hendley

13. Birthplace

England

14. Maiden name

Annie Hendley

15. Birthplace

Smithsburg, md

16. Informant

John Hendley

Address

Smithsburg, md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 1 - 1947
(month) (day) (year)

Cemetery or crematory

allegany

Location

Smithsburg, md.

18. Funeral director

J. J. Smith

Address

Smithsburg19. 12-31

(Date rec'd by registrar)

1946Mrs. Harvey H. Roe

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1946 at 800A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2 1946 to Dec 29 1946and that I last saw him alive on Dec 19 1946

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden

Due to

Chr myocarditis1 yr.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm C Lane Jr MD

M. D. or other

Address Smithsburg md Date signed 12-31-46

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JAN 3 1947

BUREAU OF

1-33

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11639

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH:

County.....Allegany
 City or town.....Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....Lifetime
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?.....4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Allegany
 City or town.....Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....959 Glenwood Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mr. Maffett Hendrickson

3. (b) Social Security Number

214-05-6398

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Single

6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....July 14, 1877

8. AGE: Years.....69 Months.....4 Days.....24 If less than one day..... hrs. min.

9. Birthplace.....Maryland
 (Town, county, and state)

10. Usual occupation.....Clerk

11. Industry or business.....W. R. Rice Grocery Store

12. Name.....John Hendrickson

13. Birthplace.....Maryland

14. Maiden name.....Sarah Gordon

15. Birthplace.....Maryland

16. Informant.....Memorial Hospital

Address.....Cumberland, Maryland

17. Burial Date thereof.....December 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Union Grove Cemetery

Location.....Near Cumberland, Md.

18. Funeral director.....J. P. Franklin

Address.....Cumberland, Md.

19. Dec 11, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....December 8, 1946 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 5, 1946 to Dec 8, 1946
 and that I last saw him alive on Dec 8, 1946

Immediate cause of death.....

Uremia
Anuria

Due to.....Chronic Diffuse Glomerular Nephritis

Due to.....

Other conditions.....Bilateral Inguinal Hernias

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

23. SIGNATURE.....J. P. Franklin M. D. or other

Address.....15 Liberty St. Date signed.....12/10/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 18 1946

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

CERTIFICATE OF DEATH

Reg. Dist. No. 116440

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 DAYSHospital, institution, or street address where death occurred:
MEMORIAL HOSPITALHow long in hospital or institution? 22 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State RI W. VA. County MINERALCity or town RIDGELEY
(If outside city or town limits, write RURAL and give nearest town)Street No. 35 KNOBLEY ST.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

HERSHBERGER, FLORENCE MRS.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED6. (b) Name of husband or wife RAYMOND E. HERSHBERGER6. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) APR. 6, 18918. AGE: Years Months Days It less than one day
55 8 12 hrs. min.9. Birthplace W. VA.
(Town, county, and state)10. Usual occupation HWEE

11. Industry or business

12. Name MORT UTTERBACH13. Birthplace W. VA.14. Maiden name MAUDE GILHOUSEN15. Birthplace W. VA.16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof 12/21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Zion Memorial CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. Dec. 19, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 18 19 46 at 7:15A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 19 46 to Dec. 15 19 46
and that I last saw him alive on Dec. 17 19 46Immediate cause of death Broncho-Pneumonia DURATION 1 dayDue to 2nd & 3rd degree burns 1 monthDue to Accidental burns - burning building not involved.Other conditions Obesity Cancer

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

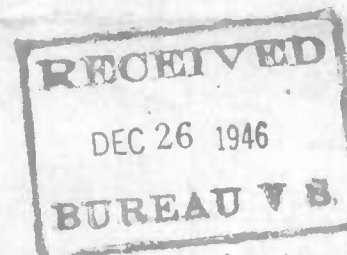
Means of injury Accidental burns Injured at work? _____23. SIGNATURE B. M. Schreiber M.D. M. D. or otherAddress 41 Greenleaf Date signed Dec 19, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Golden Set
Manufactured by
JCO



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Days
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 114 S. Smallwood St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Webster M. Hockman

3. (b) Social Security Number

214-05-5002

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nellie Hockman

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1894 6. (c) If alive, give age..... years

8. AGE: Years 52 Months 2 Days 23 If less than one day..... hrs. min.

9. Birthplace Grantsville, Md.
 (Town, county, and state)

10. Usual occupation Brewery Worker11. Industry or business Queen City Brewing Co.12. Name Henry Hockman13. Birthplace Maryland14. Maiden name Catherine Frost15. Birthplace Maryland16. Informant Mrs. Nellie HockmanAddress 114 S. Smallwood St. Cumberland

17. Burial Dec. 19, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Patricks Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.

19. Dec 19, 46 J. P. Frankli, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1946 at 1:40 P. M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from March 20, 1946 to December 16, 1946
 and that I last saw him alive on December 16, 1946

Immediate cause of death

MyocardiaSclerosis of Liver

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

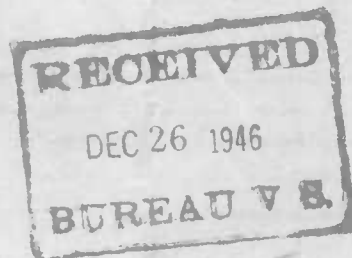
23. SIGNATURE T. Bailey Hunter M. D. or otherAddress Cumberland Md Date signed 12/18/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 938

CERTIFICATE OF DEATH

1164240
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Five weeks
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? Five weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 327 Pennsylvania Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Margaret Huff

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white widowed

6. (b) Name of husband or wife Milton L. Huff

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 - 18738. AGE: Years Months Days If less than one day
73 4 10 hrs. min.9. Birthplace Terra Alta, W. Va.
(Town, county, and state)10. Usual occupation Home11. Industry or business none12. Name Samuel Messenger13. Birthplace West Virginia14. Maiden name Mary Abraham15. Birthplace West Virginia16. Informant Mrs. Beatrice DesotoAddress Route #6 Cumberland Md17. Burial Date thereof Dec 26, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland Md18. Funeral director John J. HaferAddress Cumberland Md19. Dec. 26, 46 J. P. Franklin, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1946 to December 23 1946 and that I last saw her alive on December 23 1946

Immediate cause of death

Chronic Myocarditis

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, Md M. D. or otherAddress Cumberland Md Date signed 12-23-46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 1 1947

BUREAU V S

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-9

CERTIFICATE OF DEATH

Reg. Diat. No. 11643 80

1. PLACE OF DEATH:

County Allegany
City or town about 1/2 mile west of Mc Coole
Route 36 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Mineral
City or town Piedmont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Pearl St.
(If rural, give LOCATION)
2. (a) If veteran, name war World War # 2

3. (a) FULL NAME

James Hughes

3. (b) Social Security Number

235-30-2149

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1924

8. AGE: Years 22 Months 8 Days 20 It less than one day hrs. min.

9. Birthplace Westernport, Allegany, Md.
(Town, county, and state)

10. Usual occupation Machine Operator

11. Industry or business W. Va. Pulp & Paper Co.

12. Name James W. Hughes

13. Birthplace Vale Summit, Md.

14. Maiden name Josephine O'Neill

15. Birthplace Bloomington, Maryland

16. Informant Miss Ruth Hughes

Address Piedmont, W. Va.

17. Burial Date thereof December 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peters Cemetery

Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. Dec 7 1946 Registrar W. H. Deming
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1946 at 12.25A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive Dec. 5 1946

Immediate cause of death Fracture vertebrae of the neck and lumber region

DURATION at once

Due to

Due to

Other conditions Abdominal hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident Dec. 5-46
Where did injury occur? 1/2 Mi. west of McCoole (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 36

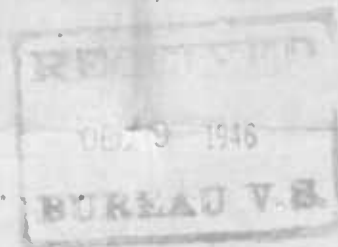
Means of injury Automobile accident

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
Address Cumtland Md Date signed 12-5-1946

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

12562 40
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

104 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 104 South St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mary Nell Irons

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Asa Irons

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Oct 31 18768. AGE: Years Months Days 9 If less than one day
70 1 1 hr. min.9. Birthplace Crown Creek Ind.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at Home12. Name Denton Buey, Ind.13. Birthplace Hannas Walford Ind.14. Maiden name Hannas Walford15. Birthplace Ind.16. Informant Asa IronsAddress Cumberland17. Burial Date thereof Dec 14 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. Dec 13 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1946 at 11:50 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Dec 10 46
and that I last saw him alive on Dec 10 46Immediate cause of death Cerebral Hemorrhage

DURATION

3 yrsDue to arteriosclerosis10 yrsDue to chronic nephritis10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D. M. D. or otherAddress 26 South Cumberland Date signed 12/1/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

BREATHERS

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

11644

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town 67 Park Ave.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Frostburg, Md.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

Raymond G. Jackson Sr.

3. (b) Social Security Number

4. Sex

Male
 5. (a) Single, married, widowed, or divorced
Married
 6. (b) Name of husband or wife Lelia Lewis
 7. Birth date of deceased (mo., day, yr.) July 21 - 1890
 8. AGE: Years 56 Months 5 Days 7 If less than one day
 5. (c) If alive, give age 49 years

8. AGE: Years 56 Months 5 Days 7 If less than one day
 5. (c) If alive, give age 49 years

9. Birthplace Frostburg, Allegany, Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Wesley Jackson

13. Birthplace Frostburg

14. Maiden name Mary Carter

15. Birthplace Frostburg, Md.

16. Informant Mrs. Raymond Jackson

Address 67 Park Ave. Frostburg, Md.

17. Burial 1-2-1947

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Joseph Graper

Address Frostburg, Md.

19. 12-31 19 46 Wesley H. Rue

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 46 at 11:17 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 19 46 to Dec - 29 19 46 and that I last saw him alive on December 29 19 46

Immediate cause of death

Carcinoma of Stomach Duration Unknown

Due to

Chronic bronchitis 5 years.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Licht, M.D.

M. D. or other

Address Frostburg, Md. Date signed 12/31/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

BUREAU V B

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1360)

11645

CERTIFICATE OF DEATH

★ Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Days
 Hospital, institution, or street address where death occurred:
11 Ridgeway Terrace
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Near Cumberland rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 122 Bedford Road, Rt. 2
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Annie Wardlow Jenkins

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
<u>Female</u>	<u>White</u>	<u>Married</u>	
6.(b) Name of husband or wife <u>Lee H. Jenkins</u>			
7. Birth date of deceased (mo., day, yr.) <u>January 31 1873</u>			
6.(c) If alive, give age <u>75</u> years			
8. AGE:	Years	Months	Days
	<u>73</u>	<u>11</u>	<u>0</u>
.....hrs.min.			

9. Birthplace Cumberland, Allegany Co, Maryland
 (Town, county, and state)

10. Usual occupation House

11. Industry or business

FATHER
 12. Name George Huffman
 13. Birthplace Cumberland, Md.
 MOTHER
 14. Maiden name Sarah Bell
 15. Birthplace Chatanooga, Tenn

16. Informant Mrs. Mabel Schwab
 Address 11 Ridgeway Terr, Cumberland, Md.

17. Burial Burial Date thereof 1/3/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mt. Pleasant Cemetery
 Location (Rural) Cumberland, Md.

18. Funeral director William H. Kight
 Address Cumberland, Md.

19. Jan 2, 47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 19 46 at 3:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 19 46 to Dec 31 19 46
 and that I last saw her alive on 12/30/46 19 46

Immediate cause of death Cardio-renal

DURATION

Due to.....

Due to.....

Other conditions arterio-sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Kester M. D. or other

Address 122 Bedford St Date signed 1/1/47

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JAN 3 1947

BUREAU V B

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

116468
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town National
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, institution, or street address where death occurred: 24
How long in hospital or institution? 24

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town National - Frostburg, P.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24
(If rural, give LOCATION)
2.(a) If veteran, name war 24

3. (a) FULL NAME

Miss Viola Keaser

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife: George Walter
7. Birth date of deceased (mo., day, yr.) - - 1884 8. (c) If alive, give age 62 years

8. AGE: Years 62 Months 0 Days 0 It less than one day 0 hrs. 0 min.

9. Birthplace National, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

12. Name George Walter

13. Birthplace Wales

14. Maiden name Sally Keaser

15. Birthplace Woodland, Md.

18. Informant Quincy Williams

Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 15, 1946
(month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

19. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. (Date rec'd by registrar) Dec 14 19 46 Jannette M. Boal Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 13 19 46, at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Dec 13 19 46
and that I last saw him alive on Nov 13 19 46

Immediate cause of death Chronic myocarditis DURATION 2 yrs

Due to Chronic myocarditis

Due to Chronic myocarditis

Other conditions Chronic myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations Chronic myocarditis

Date of op. Chronic myocarditis

Autopsy results Chronic myocarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Chronic myocarditis Date of Chronic myocarditis

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Chronic myocarditis Injured at work?

23. SIGNATURE W. M. Lane M. D. or other

Address Frostburg, Md. Date signed 12-14-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERANS AFFAIRS
OFFICE OF THE ASSISTANT SECRETARY
WASHINGTON, D. C.

RECEIVED
DEC 20 1946
BUREAU OF VETERANS AFFAIRS

2-35

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11647 40

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 52 yrs

Hospital, institution, or street address where death occurred:

9 W. Oldtown Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 W. Oldtown Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Michael J. Kean

3. (b) Social Security Number

705-10-78764. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 27 18948. AGE: 52 Years 4 Months 12 Days 12 hr. 12 min.9. Birthplace Cumberland Ind
(Town, county, and state)10. Usual occupation Telephone operator11. Industry or business R. & D. R.R.12. Name Michael Kean13. Birthplace Ireland14. Maiden name Anna Studdard15. Birthplace Ireland16. Informant Miss Della KeanAddress Cumberland17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 12 46
(month) (day) (year)Cemetery or crematory St. Patrick's CemLocation Cumberland Ind18. Funeral director Louis Stein IncAddress Cumberland19. Dec. 12, 46 (Date rec'd by registrar)

J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1946 at 230P21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12 2 to Dec 9 46and that I last saw him alive on Dec 9 1946Immediate cause of death Cerebral Hemorrhage DURATIONChronic HepatitisHypertension

Due to

Other conditions

(Include pregnancy within months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE R.F. Williams M. D. or otherAddress Cumberland Date signed 12.10.46

RECEIVED

DEC 18 1945

BUREAU OF AERONAUTICS

2-35

DR. W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11648

Reg. Dist. No.

40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3.0 yrs

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 1 HOUR

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 800 WASHINGTON ST.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. ELMER, R. KELLOUGH

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife Lucy Phares7. Birth date of deceased (mo., day, yr.) June 18 1888

6. (c) If alive, give age..... years

8. AGE: Years 58 Months 6 Days 7 If less than one day
..... hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Pharmacist11. Industry or business Retired12. Name Robert Kellough13. Birthplace Md.14. Maiden name Barbara Vaden15. Birthplace Md.16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial & Removal Date thereof Dec 20 '46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington CemLocation Clemons St Va18. Funeral director Louis Stein Inc.Address Cumberland19. Dec 27 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 25 19 46 at 4:03 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5:15 19 45 to 12:25 19 46and that I last saw him on 12 25 19 46Immediate cause of death Cerebral Hemorrhage DURATION 3Chronic Hepatitis R.T.Due to C Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.F. Williams M.D. or otherAddress Cumberland Date signed 12-26-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 2 1947
BUREAU V S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63

11649

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

MEMORIAL,How long in hospital or institution? 17 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town PINTO
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

BIRD KISER

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife BYRON H. KISER6. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) DEC. 27, 18838. AGE: Years Months Days If less than one day
63 0 2 hrs. min.9. Birthplace W. VA.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name PATRICK DAYTON13. Birthplace W. VA.14. Maiden name AMANDA WAGONER15. Birthplace W. VA.16. Informant Byron KiserAddress Pinto, Md.17. Burial Date thereof Dec. 31, 1946
(Burial, cremation, or removal. Which?) (month)/(day) (year)Cemetery or crematory Ft. Ashby CemeteryLocation Ft. Ashby, W. Va.19. Funeral director John J. HoffAddress Cumberland, Md.19. Dec. 30, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 29 1946 at 9:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-12-1946 to 12-29-1946and that I last saw him alive on 12-28-1946

Immediate cause of death _____ DURATION _____

Cerebral Thrombosis 3 wks.Due to GeneralizedDue to Arteriosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. F. Williams M.D. or other _____Address Cumberland Date signed 12-29-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 3 1947

BUREAU

1-35

DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1672

CERTIFICATE OF DEATH

11650

Reg. Dist. No.

40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CRESAPTOWN
(If outside city or town limits, write RURAL and give nearest town)Street No. WINCHESTER ROAD
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

BABY GIRL KLEIN

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITEINFANT

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) DEC. 27, 19468. AGE: Years Months Days If less than one day
0 0 3 hrs. min.9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name HOWARD A. KLEIN13. Birthplace W. VA.14. Maiden name MARGUERITE DONNELLY15. Birthplace W. VA.16. Informant Howard A. KleinAddress Cresaptown, Md.17. Burial Date thereof Dec 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bethel CemeteryLocation Little Cacapon W. Va18. Funeral director John J. HalerAddress Cumberland, Md.19. Dec 30, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 30, 1946 19 46 at 1:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 19 46 to Dec 30 19 46and that I last saw h. 62 alive on Dec 30 19 46Immediate cause of death Septicemic disease of the newbornDURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M.D. M. D. or otherAddress Medel Bldg Date signed 12-30-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

BUREAU VS

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 68

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town LaVale, Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Parkside Side Ave. La Vale

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Rural LaVale, Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Park Side Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Viola Melvina Knippenberg

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife James A. Knippenberg

7. Birth date of deceased (mo., day, yr.)

March 27, 1887

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59

8

27

hrs.

min.

9. Birthplace

Oldtown, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Conrad Shatzer

13. Birthplace

Oldtown, Md.

14. Maiden name

Sidney R. Danells

15. Birthplace

Oldtown, Md.

16. Informant

Mrs. W.C. Somerville

Address

LaVale, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof Dec 27, 1946
(month) (day) (year)

Cemetery or crematory

Hillcrest Cem.

Location

Cumberland, Md.

18. Funeral director

Louis Stein Inc.

Address

Cumberland, Md

Dec. 27, 46
(Date rec'd by registrar)

J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 19 46 at 9 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....
and that I last saw h... er Dead Dec. 26 19 46

Immediate cause of death

Myocarditis

DURATION

several
years

Due to

Due to

Other conditions Thyro-toxemia

(Include pregnancy within 8 months of death)

several
years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 12.24/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 1 1947
BUREAU V S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 11652/0

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs.
 Hospital, institution, or street address where death occurred
715 Bedford St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 715 Bedford St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Annice Marie Kolb

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Charles E. Kolb
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept 3 1869

8. AGE: Years 77 Months 3 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Brown Spring W. Va.
 (Town, county and state)

10. Usual occupation Housewife
 11. Industry or business at Home

12. Name John Derr
 13. Birthplace W. Va.

14. Maiden name Sarah Gurlow
 15. Birthplace Ind.

16. Informant Dr. Karl W. Kolb
 Address Cumberland

17. Burial, cremation, or removal, Which? Burial Date thereof Dec 10 46
 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.
 Location Cumberland

18. Funeral director Wm. Stein Inc
 Address Cumberland

19. Dec 10, 46 J. P. Traubner, M.D. Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 19 46, at 7A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 19 46 to Dec 8 19 46 and that I last saw him alive on Dec 8 19 46

Immediate cause of death Coronary Thrombosis
 Due to Arteriosclerosis
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. P. Traubner, M.D. M. D. or other
 Address Med Bldg Date signed 12/10/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

RECEIVED

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11653

4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 76 years
 Hospital, institution, or street address where death occurred:
Queen City station, Cumberland, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 221 Baltimore Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Dr. Thomas W. Koon

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Fannie Hutson 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 12, 1870
 8. AGE: Years 76 Months 0 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Newberry Co., S. Carolina
 (town, county, and state)
 10. Usual occupation Physician
 11. Industry or business Medical Doctor
 12. Name Walter Koon
 13. Birthplace Newberry Co., S. Carolina
 14. Maiden name Laura R. Suber
 15. Birthplace Newberry Co., S. Carolina

16. Informant Lindley Sloan
 Address Washington St., Cumberland, Md.
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof December 8, 1946
 (month) (day) (year)
 Cemetery or crematory Rose Hill Mausoleum
 Location Cumberland, Md.

18. Funeral director John J. Hoff
 Address Cumberland, Md.
 19. (Date rec'd by registrar) Dec 6 1946 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 19 46 at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him Dead Dec. 5 19 46

Immediate cause of death Coronary thrombosis
 Due to Arterio-sclerosis and
varicose veins

DURATION
at once
several
years

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
 M. D. or other _____
 Address Cumberland Md Date signed 12-5-1946

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 10 1946

BUREAU T 3

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

11654
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Allegheny Hospital 215 Decatur St.
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Hancock
 City or town Hancock, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Joseph Charles Landers

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Ida Belle Landers6. (c) If alive, give age 66 years7. Birth date of deceased (mo., day, yr.) July 3, 18778. AGE: Years Months Days If less than one day
69 5 17 hrs. min.9. Birthplace Maryland, Hancock, Washington Co.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Joseph Landers
13. Birthplace Shropshire, England14. Maiden name Mary Mendenhall
15. Birthplace Cecil County Maryland16. Informant Mrs Joseph C LandersAddress Rt 2, Hancock, Md.17. Burial Date thereof 12/24/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rehobeth CemeteryLocation (Near) Hancock, Md.18. Funeral director Charles R. BestAddress Hancock, Md.19. Dec. 21, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20-46 at 8:05 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19, 1946 to December 20, 1946 and that I last saw him alive on December 20, 1946

Immediate cause of death

DURATION

Globar Pneumonia 4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

M. D. other

Address Cumberland, Md. Date signed 12-21-46

MARGIN RESERVED FOR BINDING

VS A45 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 26 1946

BUREAU V B

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 11655 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 Yrs.

Hospital, institution, or street address where death occurred:

319 Cumberland St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 319 Cumberland St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank Albert Leasure

3. (b) Social Security Number

214-05-8472

4. Sex

Male

5. Color or race

White

8.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Julia Frantz

6.(c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Oct. 30 18818. AGE: Years 65 Months 1 Days 7 If less than one day
hrs. min.9. Birthplace Penna.
(Town, county, and state)10. Usual occupation Sales Mgr. (Retired.)11. Industry or business Atlantic & Pacific Tea Co.12. Name Lafayette Leasure13. Birthplace Penna.14. Maiden name Agnes Hamilton15. Birthplace Penna.16. Informant Mrs. F.A. LeasureAddress Cumberland, Md17. Burial Date thereof 12/11/1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Ceme.Location Cumberland, Md18. Funeral director Louis Stein, IncAddress Cumberland, Md19. Dec 11 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1946 at 11:20

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 7 1946 to Dec 7 1946and that I last saw him alive on Dec 7 1946

Immediate cause of death

DURATION

Coronary thrombosis

Due to

Arterio sclerosis

Due to

Arterio sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. P. Franklin, M.D.

M. D. or other

Address West 3rd Date signed 12/10/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

READ 12

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-24

CERTIFICATE OF DEATH

Reg. Dist. No. 116540

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs
 Hospital, institution, or street address where death occurred:
231 Elder St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 231 Elder St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cora Agnes Sepley

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Dalton B. Sepley
 6. (c) If alive, give age 61 1/2 years
 7. Birth date of deceased (mo., day, yr.) June 23, 1890
 8. AGE: Years 56 Months 6 Days 3 If less than one day
 hrs. min.

9. Birthplace Flintstone, Allegany Co., Md.
(Town, county, and state)10. Usual occupation House work11. Industry or business at home12. Name Olinus H. McCoy13. Birthplace Flintstone, Md.14. Maiden name Mucilla Ruby15. Birthplace Beans Cove Pa.16. Informant Dalton B. SepleyAddress 231 Elder St. - Cumberland Md17. Burial Date thereof Dec 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Berkeley Springs CemLocation Berkeley Springs W. Va18. Funeral director John J. HahnAddress Cumberland Md19. Dec 28 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26, 1946 at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 19, 46 to December 46
 and that I last saw her alive on December 23, 46

Immediate cause of death

apoplexyDue to hypertensionDue to myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Baile Hunter MD M. D. or otherAddress Cumberland Md Date signed 12/26/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 1 1947.

STANDARD

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (952)

CERTIFICATE OF DEATH

11657

Reg. Dist. No.

40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 43 Years
 Hospital, institution, or street address where death occurred:
122 Independence St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 122 Independence St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Emory Mayberry Lewis

3. (b) Social Security Number

217-10-6775

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Amanda Lewis
 6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) April 21 1872

8. AGE: Years 74 Months 8 Days 2 If less than one day
 hrs. min.

9. Birthplace Middletown, Frederick Co, Virginia
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Building Houses

12. Name Gordon Lewis

13. Birthplace Middletown Virginia

14. Maiden name Sarah Rhodes

15. Birthplace Middletown, Va.

16. Informant Edgar M. Lewis

Address 122 Independence St, Cumberland, Md.

17. Burial Date thereof 12/26/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Knight

Address Cumberland, Md.

19. Dec. 26 19 46 J. P. Frankel, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 46 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15/46 19 to 12/23/46 19
 and that I last saw him alive on 12/23/46 19

Immediate cause of death Pulmonary Embolism DURATION
Chronic myocarditis

Due to staphylococcal sepsis of age
 Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

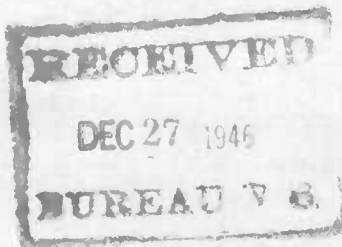
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Frankel, M.D. M.D. or other

Address Cumberland, Md. Date signed 12/23/46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1165840
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 70 yrs
 Hospital, institution, or street address where death occurred: Memorial Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 630 Hilltop Drive
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

John Lawrence Mathews

3. (b) Social Security Number

705-05-6248

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Helen Chapline
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Sept 26 1876
 8. AGE: Years 70 Months 2 Days 13 It less than one day hrs. min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)
 10. Usual occupation Retired Chief Train Dispatcher
 11. Industry or business B & O Ry.

12. Name James A Mathews
 13. Birthplace Ind.
 14. Maiden name Florence E Cookus
 15. Birthplace N. Va.

16. Informant Mrs John A. Mathews
 Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12/11/46
 (month) (day) (year)
 Cemetery or crematory Rose Hill Ceme.
 Location Cumberland, Ind.
Louis Stein Inc.

18. Funeral director Louis Stein Inc.
 Address Cumberland, Ind.

19. Dec. 11, 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 19 46, at 4:15 A.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....
 and that I last saw him alive on 19.....

Immediate cause of death Cerebral Thrombosis DURATION 2 days
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE John A. Laffer MD M. D. or other
 Address Hydromant Date signed 12-9-46

RECEIVED

DEC 18 1946

BUREAU

2-35-

Dr. Tupper

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161-2

11659

CERTIFICATE OF DEATH

Reg. Diat. No. 40

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL CUMB. MD.
 How long in hospital or institution? 1 HR. 23 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town near CUMBERLAND, MD. rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. RT. #4
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

BABY BOY MCCRAW

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE
 6.(b) Name of husband or wife
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) DEC 17, 1946
 8. AGE: Years _____ Months _____ Days _____ If less than one day
I hrs. 23 min.

9. Birthplace CUMBERLAND MD.
(town, county, and state)

10. Usual occupation

11. Industry or business

12. Name JEREMIAH T. MCCRAW13. Birthplace MD.14. Maiden name CATHERINE PROPST15. Birthplace W. VA.16. Informant Memorial HospitalAddress Cumberland, Md.17. Burial Date thereof Dec. 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. Dec 19, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 18 1946 at 12:35 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17 1946 to December 18 1946 and that I last saw him alive on December 18 1946Immediate cause of death Congenital Atelectasis DURATION 1 hour 23 minutes

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D. M. D. or otherAddress Cumberland, Md. Date signed 12-18-46

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 26 1946
BUREAU V.E.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 11660 96

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred: Queen's Hospital
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Tarrett
 City or town Rural Frostburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt. 2
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Mrs. Clara Agnes Eaton McPerrine

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Peter A. McPerrine
 6. (c) If alive, give age 59 years
 7. Birth date of deceased (mo., day, yr.) Feb. 5 - 1887

8. AGE: Years 59 Months 10 Days 7 It less than one day hrs min.

9. Birthplace Tarrett Co., Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Domestic

12. Name Peter Eaton

13. Birthplace Tarrett Co., Md.

14. Maiden name Clara McPerrine

15. Birthplace Tarrett Co., Md.

16. Informant Mrs. Peter McPerrine

Address Frostburg, Md.

17. Burial Date thereof 12/12/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's Cemetery

Location Tarrett Co., Md.

18. Funeral director Jacob Wagner

Address Frostburg, Md.

19. 12-12 46 Mrs. Nancy N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1946, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945 to Dec 10 1946

and that I last saw him alive on 12/10 1946

Immediate cause of death Hypostatic pneumonia DURATION 24 hrs

Due to Arteriosclerotic cardiovascular renal disease 3 years

Due to Cholera stit

Other conditions Cholera stit

(Include pregnancy within 3 months of death)

Major findings of operations Cholera stit

Date of op. 12/10/46

Autopsy results Cholera stit

PHYSICIAN: Please underline the cause to which death should be charged statistically.

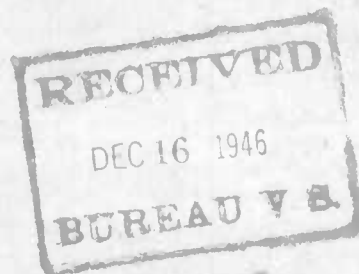
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Cholera stit Date of 12/10/46

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda J. Walters M.D. M. D. or other
 Address Frostburg, Md. Date signed 12/10/46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

CERTIFICATE OF DEATH

Reg. Dist. No. 1001

1. PLACE OF DEATH:

County alleganyCity or town mt Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. Dec 21

(Date rec'd by registrar)

1946

Vernonia M. Dermott

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 18th 1946 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1945 to December 18th 1946and that I last saw him alive on Dec - 17th 1946

Immediate cause of death

Coronary Thrombosis -

Due to

Generalized Arterio Sclerosis

Due to

Other conditions

Myocarditis &
Vascular Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William E. Musely, M.D.

M. D. or other

Address

mt Savage md.

Date signed

12/21/46

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DEC 27 1946

BUREAU V.B.

2-38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11662

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40
 Hospital, institution, or street address where death occurred:
512 Springdale Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 512 Springdale Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

William McKinley

3. (b) Social Security Number

705-09-9899

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bella Marie McKinley6. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) November 28 1883

8. AGE: Years 63 Months 0 Days 24 It less than one day hrs. min.

9. Birthplace Elk Garden, Mineral Co., W. Va.
(Town, county, and state)10. Usual occupation Car Knocker11. Industry or business Baltimore & Ohio Railroad12. Name William McKinley13. Birthplace Unknown14. Maiden name Christie McKinley15. Birthplace Elk Garden, W. Va.16. Informant Mrs. William McKinleyAddress 512 Springdale St, Cumberland, Md.17. Burial Date thereof 12/26/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Md.16. Funeral director William H. KightAddress Cumberland, Md.19. Dec 26, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1946 at 8-30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22, 1946 to Dec. 22, 1946
 and that I last saw him alive on Dec. 22, 1946

Immediate cause of death

DURATION

Coronary ThrombosisDue to 15 min

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. LumaAddress Cumberland M. D. or otherDate signed 12/23/46

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JAN 2 1947

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11663

Reg. Dist. No.

40

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Pennsylvania County Bedford CoCity or town Real Cumberland Valley
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Albert Miller

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Ada Howard7. Birth date of deceased (mo., day, yr.) 18 788. AGE: Years 68 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Penna
(Town, county, and state)10. Usual occupation Sawyer11. Industry or business Timber12. Name Arch Miller13. Birthplace Pa.14. Maiden name Beatrice Becker15. Birthplace Pa.16. Informant Norman H MillerAddress Cumberland Ind17. Burial Date thereof Dec 24 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Odd Fellowship Cem.Location Centerville, Pa.18. Funeral director Louis H. HinesAddress Cumberland, Ind.19. Dec 24 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 19 46 at 2:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21 19 46 to Dec 22 19 46 and that I last saw him alive on December 21, 1946Immediate cause of death Cardio Renal DiseaseDue to Exposure & Shock

Due to _____

Other conditions _____
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Bailey Hunter M.D.
M. D. or other _____Address Cumberland Ind Date signed 12/23/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JAN 2 1947

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

11684

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred: Sylvan Retreat
 How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Midland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Gavin W. Morton

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Hester Morton

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) February 14, 1872

8. AGE: Years 74 Months 9 Days 26 If less than one day hrs. min.

9. Birthplace Detmold, Allegany Cty, Md.
(Town, county, and state)

10. Usual occupation Retired miner

11. Industry or business Coal mines

12. Name John Morton

13. Birthplace Scotland

14. Maiden name Margaret Jackson

15. Birthplace Scotland

16. Informant Mrs. Gerald Anderson

Address Midland Md.

17. Burial Date thereof 12-12-46
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director J. J. Stewart

Address Frostburg Md.

19. Dec 11, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 1946 to Dec. 10 1946 and that I last saw him alive on Dec. 9 1946

Immediate cause of death Chronic Poisoning DURATION 1 wk

Due to Chronic Nephritis 4 yrs +

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other

Address 110 S. Centre St. Date signed 12-11-46

2001

RECEIVED

DEC 18 1946

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No.

11696

1. PLACE OF DEATH:

County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week
 Hospital, institution, or street address where death occurred:
Miners' Hospital
 How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. 3 D. 1 Box 20
 (If rural, give LOCATION)
 2. (a) If veteran, name war...

3. (a) FULL NAME

Rachel Ware Neilson

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Thomas Neilson
 6. (c) If alive, give age 73 years
 7. Birth date of deceased (mo., day, yr.) April 20, 1878
 8. AGE: Years 68 Months 7 Days 11 It less than one day
 hrs. min.

9. Birthplace Frostburg, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation housewife
home

11. Industry or business

12. Name John Ware

13. Birthplace Pennsylvania

14. Maiden name Harriet Miller

15. Birthplace Pennsylvania

16. Informant Mrs. Thos. Neilson, Jr.
 Address Frostburg, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 4-1946
 (month) (day) (year)
 Cemetery or crematory Allegany Cemetery
 Location Frostburg, Md.

18. Funeral director J. J. Keirst
 Address Frostburg, Md.

19. 12-3 19. 46 Mrs. Harvey N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 19. 46 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25 19. 46 to December 2 19. 46
 and that I last saw him alive on December 1 19. 46

Immediate cause of death

Acute nephritis

Due to

Diabetes mellitus

Other conditions HT: Jmoral anemia

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Shick M.D. M. D. or other

Address Frostburg, Md. Date signed 12/3/46

RECEIVED

DEC 6 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (109)

11667

CERTIFICATE OF DEATH

Reg. Diat. No. 40

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1114 Lafayette Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1114 Lafayette Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Ronnie Eldon Park

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of

deceased (mo., day, yr.)

July 26, 1946

8. AGE:

Years

Months

Days

If less than one day

0428

hrs.

min.

9. Birthplace Cumberland, Allegheny Co., Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

FATHER
MOTHER

12. Name

Lyle Park

13. Birthplace

Moorefield, W. Va.

14. Maiden name

Margaret Mc Kee

15. Birthplace

Kirby, W. Va.

16. Informant

Lyle ParkAddress 1114 Lafayette Ave, Cumberland, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 27, 1946
(month) (day) (year)

Cemetery or crematory

Robury Cemetery

Location

Robury, W. Va.

18. Funeral director

John J. H. H. H.

Address

Cumberland, Md

19. Dec. 26, 46

(Date rec'd by registrar)

J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1946 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him Dead Dec 26, 1946

Immediate cause of death

Acute congestion of the lungs due to edema

DURATION

Due to

Due to

Other conditions One of twins, always weak from birth.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner - Allegheny Co.23. SIGNATURE H. V. Derrington M.D.
M. D. or otherAddress Cumberland, Md Date signed 12.26/46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 2 1947
BUREAU V B

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1166840

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, Maryland

How long in hospital or institution?

16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County WetzelCity or town Romney
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Frances A. Parker

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mr. James A. Parker

7. Birth date of deceased (mo., day, yr.)

12/7/1871

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75020

hrs.

min.

9. Birthplace

West Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Kathert Gross

13. Birthplace

Apperille, Virginia

14. Maiden name

Sally Taylor

15. Birthplace

Romney, West Virginia

16. Informant

Mrs. Clarence Scanlon

Address

Romney, W. Va.

17. Burial

(Burial, cremation, or funeral. Which?)

Date thereof

Dec 30, 1946

Cemetery or crematory

Methodist Memorial Cem.

Location

Romney, W. Va.

18. Funeral director

Thrush's Funeral Home

Address

Romney, W. Va.

19. Dec 30, 1946

(Date rec'd by registrar)

20. J. P. Franklin M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 19 46 at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/15 19 46 to 12/27 19 46
and that I last saw him alive on 12/27 19 46

Immediate cause of death

ch. leukemia

DURATION

Due to

metastases of the lung

Due to

cancer of the breast

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Elizabeth Gross, M.D.

M.D. or other

Date signed

12/28

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

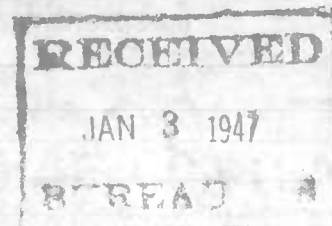
5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

11669

Reg. Dist. No. 40

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hrs
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 6 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cleatown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Baby Parks

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife _____
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Dec 27 1946
8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hrs. 15 min.

9. Birthplace Cumberland Ind
(Town, county, and state)
10. Usual occupation None
11. Industry or business _____
FATHER 12. Name Lee Parks
13. Birthplace N. Va.
MOTHER 14. Maiden name Mamie Roach
15. Birthplace Spring Gap Ind
16. Informant Memorial Hosp
Address Cumberland
17. Burial Date thereof Dec 28 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Int Labor Cem.
Location Spring Gap Ind
18. Funeral director Louis Stem Inc
Address Cumberland
19. 12-28- 19 46 J. P. Nauklien, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 19 46 at 12:15 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 19 46 to Dec 27 19 46
and that I last saw him alive on Dec. 27 19 46
Immediate cause of death Premature
DURATION _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____
Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Clayton J. Furr
M. D. or other _____
Address Cumberland Date signed 12/28/46

RECEIVED

JAN 2 1947

BUREAU V B.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 142

CERTIFICATE OF DEATH

11670

Reg. Dist. No. 80

1. PLACE OF DEATH:

County Allegheny
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 8 hrs - 8 m - 15 days
Hospital, institution or street address where death occurred:
Detmold Street
How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Detmold St.
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

William Pickens Peebles

3. (b) Social Security Number

376-10-5487

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Jennie Langley Peebles

7. Birth date of deceased (mo., day, yr.) April 1, 1898

8. AGE: 48 Years 8 Months 15 Days If less than one day _____ hrs. _____ min.

9. Birthplace Lonaconing, Allegheny Co., Md.
(Town, county, and state)

10. Usual occupation Belarusk Worker

11. Industry or business Celanese Corporation

12. Name Thomas Peebles

13. Birthplace Lonaconing, Md.

14. Maiden name Mary Pickens

15. Birthplace Lonaconing, Md.

16. Informant Mrs. Earl Stiffing

Address Middland, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec. 18, 1946
(month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

16. Funeral director W. Dickson

Address Lonaconing, Md.

19. Dec 17 1946 (Date rec'd by registrar)

Registrar Janet M. Boal

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1946 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10th 1946, to Dec. 16 1946

and that I last saw him alive on Dec. 16 1946

Immediate cause of death Chronic nephritis

Due to _____ DURATION _____

Due to _____

Other conditions Heart Ulcer

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harry Dr. Hodgson by 10

M. D. or other _____

Address Lonaconing, Md. Date signed Dec. 17 '46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
ALBANY, N. Y.

RECEIVED

DEC 20 1946

BUREAU OF VITAL RECORDS

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

11674
Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 61 yrs.
 Hospital, institution, or street address where death occurred:
515 Greene St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 515 Greene St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Derota Rawlings

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Wm H Rawlings
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec 1 1885

8. AGE: Years 61 Months - Days 13 It less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at home

12. Name Richard M. Edwards

13. Birthplace Ind.

14. Maiden name Anna B. Butler

15. Birthplace Ind.

16. Informant Enis Reckie D. Rawlings

Address Cumberland

17. Burial Date thereof Dec 17 46
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Steiner Inc.

Address Cumberland

19. Dec 17 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 46 3:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to Dec 14 46 and that I last saw her alive on Dec 14 46

Immediate cause of death

Crowning thrombosis 5 minutes

Due to Hypertensive C.V. Disease 2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

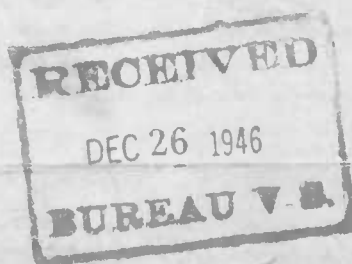
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE B. Franklin M. D. or other

Address 411 E. 1st St. Date signed Dec 16 46



2-35

Mr. Schneider

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ~~Write~~ correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11672

Reg. Dist. No. 00

1. PLACE OF DEATH:

County Allegheny
 City or town Cresaptown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life long resident
 Hospital, institution, or street address where death occurred:
5 S. Winchester Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
 City or town Cresaptown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5 S. Winchester Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Catherine Henriette Rhodes

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife John Rhodes
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) March 21, 1878

8. AGE: Years 68 Months 8 Days 11 If less than one day..... hrs. min.

9. Birthplace Cresaptown Allegheny Co, Md
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

12. Name Abraham F. Ferghelger

13. Birthplace Garnett Co. Md.

14. Maiden name Matilda Shuck

15. Birthplace Cresaptown Md.

16. Informant Mrs. Jack Malone

Address 421 Louisiana Ave - Camb. Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 4, 1946
 (month) (day) (year)

Cemetery or crematory Shillert Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafery

Address Cumberland Md.

19. 12/2 46 MA Registrar

(Date rec'd by registrar) 19 46

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 19 46 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 19 46 to Dec 1 19 46
 and that I last saw him alive on Dec 1 19 46

Immediate cause of death Cerebral Hemorrhage with
Intestinal Distention

DURATION

6 mos
1 wk

Due to.....

Due to.....

Other conditions Arteriosclerosis, acute
Pulmonary infarct
 (Include pregnancy within 3 months of death)

2 wk
2 wk

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Will C. Weisman MD
 M. D. or other

Address Cresaptown Date signed Dec 2, 1946

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DEC 13 1946
BUREAU OF

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

11673

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Emmetsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs.
 Hospital, institution, or street address where death occurred:
614 Central Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Emmetsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 614 Central Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George Washington Rinker

3. (b) Social Security Number

705-09-9691

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Evelyn F. Geets

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age. years

Aug 14 1879

8. AGE: Years Months Days If less than one day

67 4 14 hrs. min.

9. Birthplace

Como Brook Va.
(Town, county, and state)

10. Usual occupation

Crooner

11. Industry or business

B & O Ry

12. Name

Loomis Rinker

13. Birthplace

Va.

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Barren R. Rinker

Address

Emmetsburg

17. (Burial, cremation, or removal. Which?) Date thereof

Burial Dec 31 46
(month) (day) (year)

Cemetery or crematory

James' (Rm) Burial Park

Location

Lost River N. Va.

18. Funeral director

Loma Stein Inc.

Address

Emmetsburg

19. Dec 30 19 46 J. P. Franklin M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 19 46 at VA

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/1/46 19. to 12/28/46and that I last saw h. i. m. alive on 12/28/46 19.

Immediate cause of death

Coronary Thrombosis

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. J. Williams M.D.

Address

Emmetsburg Md

Date signed

12/30/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CEREBRUM RESERVED FOR BINDING

RECEIVED

JAN 3 1947

BUREAU V

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

11674 40

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 years
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 227 Paca Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Mary A. Ritter

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
8.(b) Name of husband or wife Jacob Ritter
7. Birth date of deceased (mo., day, yr.) Dec. 29, 1874
8. AGE: Years 71 Months 11 Days 23 If less than one day

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation House-work
11. Industry or business

12. Name John Hext (Deceased)
13. Birthplace England
14. Maiden name Ellen Curley (Deceased)
15. Birthplace Pa.

16. Informant Allegany Hospital
Address 215 Decatur Street
17. Burial Date thereof Dec 24, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount
Location Baltimore

18. Funeral director Charles T. George
Address 202 Green St
19. Dec. 24 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 19 46 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Dec. 19 46 to 22 Dec. 19 46
and that I last saw 22 alive on 21 Dec. 46 19

Immediate cause of death Coronary & bronchitis, Problems
Pattern DURATION 1 week
Due to skate pellets
Due to Hypertension Heart Disease?
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. A. V. O. M. D. M. D. or other
Address 110 S. Cal St. Date signed 24 Dec. 46
Cumberland, Md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

JAN 2 1947

BUREAU V S

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

11675 9
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
Centennial St. Ext.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Centennial St. Ext.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Rosa Frances Robinson

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Richard Robinson

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) September 2, 1873

8. AGE: Years 73 Months 3 Days 9 If less than one day
hrs. min.

9. Birthplace Marysville, Somerset Co., Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Thomas E. Ravenscroft

13. Birthplace Garrett Co., Md.

MOTHER 14. Maiden name Maria Murphy

15. Birthplace Garrett Co., Md.

16. Informant Richard Robinson

Address Frostburg, Md.

17. Burial Date thereof December 14, 1946
(Burial, cremation, or removal. Whole) (month) (day) (year)

Cemetery or crematory Blecker Cemetery

Location near Frostburg - Garrett Co.

18. Funeral director John J. Hefner

Address Chesapeake, Md.

19. 12-14 19. 46 Dr. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to 12/11
and that I last saw him alive on 12/10

Immediate cause of death Arteriosclerotic heart disease

DURATION

4 yrs

Due to

Due to

Other conditions Pt pleurisy & possible pneumonia
(Include pregnancy within 3 months of death)

1 wk

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Juszewsky M.D.

Address Frostburg, Md. Date signed 12/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS DEPARTMENT OF HEALTH

For the County of Middlesex

CERTIFICATE OF DEATH

State of Massachusetts

County of Middlesex

Town of Boston

Ward of South Boston

Block of 100

House of 100

Room of 100

Apartment of 100

Office of 100

Store of 100

Warehouse of 100

Factory of 100

Workshop of 100

Garage of 100

Stable of 100

Pen of 100

Enclosure of 100

Field of 100

Orchard of 100

Vineyard of 100

Garden of 100

Yard of 100

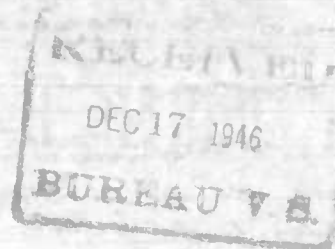
Plot of 100

Tract of 100

Parcel of 100

Lot of 100

Site of 100



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

11676

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 min.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 10 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town 6 Mi. South Friendsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) _____
2.(a) If veteran, name war _____

3. (a) FULL NAME
Alvin Rodeheaver

3. (b) Social Security Number
213-24-6252 ✓

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Doris Friend Rodeheaver
6. (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) July 5, 1903
8. AGE: Years 43 Months 5 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Preston Co., W. Va.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Own Farm
12. Name Jackson Rodeheaver
13. Birthplace Preston Co., W. Va.
14. Maiden name Sarah Jane Mangus
15. Birthplace Preston Co., W. Va.

16. Informant Leslie Rodeheaver
Address R. D. Friendsville, Md.

17. Burial Dec. 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Sang Run Cemetery
Location Garrett Co., Md.

18. Funeral director Herbert C. Lightton
Address Oakland, Maryland.

19. Dec 31 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1946 4:30P/ M

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from 27 Dec 1946 to 27 Dec 46 and that I last saw him alive on 27 Dec 46 19

Immediate cause of death Coronary Heart Disease

Due to Obesity

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Leslie Rodeheaver M. D. or other

Address Oakland Md Date signed 30 Dec 46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

BUREAU

1-38

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (4)
CERTIFICATE OF DEATH

★ Reg. Dist. No. 11687 40

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
227 Saratoga St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 227 Saratoga St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME Edward William Rohman

3. (b) Social Security Number 712-85-0799

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Reta G. Hunt

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Sept 19, 1887

8. AGE: Years 59 Months 3 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Ind.
(Town, county, and state)

10. Usual occupation Service foreman

11. Industry or business Telephone Co.

12. Name Cooper Rohman

13. Birthplace Ind.

14. Maiden name Matthilda Chubar

15. Birthplace Ind.

16. Informant Mrs. Reta Rohman

Address Cumberland

17. Burial Date thereof Jan 2 '47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter & Pauls Cem.

Location Cumberland

18. Funeral director Louis Stein

Address Cumberland

19. Jan 2 19 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 46 at 1:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 19 46 to 31 Dec. 19 46
and that I last saw him alive on 30 Dec. 19 46

Immediate cause of death Cerebral Hemorrhage DURATION 2 weeks

Due to Diabetes mellitus ?

Due to arterial hypertension ?

Due to arteriosclerosis, general !

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE W. Alfred Von Oers M. D. or other
Address Cumberland, Md. Date signed 1 Jan 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

BUREAU 3

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32-a)

11678

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleghenyCity or town Buttsford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:

Cremorial HospitalHow long in hospital or institution? 215 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Buttsford
(If outside city or town limits, write RURAL and give nearest town)Street No. 802 Fayette St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Antoinette Rosenbaum

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Joseph Rosenbaum

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

80230

hrs.

min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

Salomon Frankel

12. Name

13. Birthplace

Germany

14. Maiden name

Sara Hamburg

15. Birthplace

Germany

16. Informant

Miss Harry Benemer

Address

Buttsford

17. Burial, cremation, or removal, Which?

Burial

Date thereof

Jan 3 47

(month) (day) (year)

Cemetery or crematory

Helsor born

Location

Uniontown Pa

18. Funeral director

Louis Stein Inc

Address

UniontownJan 2, 1947J. P. Franklin, M.D.Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 46 at 10:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 30 19 46 to December 31 19 46and that I last saw her alive on December 31 19 46

Immediate cause of death

Infectious Hepatitis+ Complete AnemiaCentral Nervous SystemDistal Myelitis

DURATION

16 days3 days2514 years5555555555555555555555555

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

1/2/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

BUREAU

1-38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11679

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
518 Avondale Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 518 Avondale Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Margaret "Fogerty" Rowley

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Thomas Rowley

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) August 15, 1876

8. AGE: Years 70 Months 4 Days 6 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name James Fogerty

13. Birthplace Ireland

14. Maiden name Mary Price

15. Birthplace Ireland

16. Informant Mrs. T.R. McDonald

Address 518 Avondale Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 24, 1946
(month) (day) (year)

Cemetery or crematory St. Patricks Cemetery

Location Cumberland, Maryland.

18. Funeral director John J. Staker

Address Cumberland, Maryland

19. Dec 24 46 Registrar J. Franklin, Md.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21st 1946 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-13 1946 to Dec 21 1946

and that I last saw him alive on Dec 21 1946

Immediate cause of death

Carcinoma of

Due to Recess

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. Macskeen M. D. or other

Address 179 Green St Date signed 12-24-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 7 1947

BUREAU V.C.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

11680

1. PLACE OF DEATH:

County Allegany HospitalCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, Md.How long in hospital or institution? 2 hrs. 45 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 241 Columbia St.
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Robert Charles Ruppert, Jr.

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

12/16/46

8. AGE:

Years

Months

Days

If less than one day

13

hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business _____

FATHER

12. Name Robert Ruppert, Sr.13. Birthplace Cumberland, Allegany, Md.

MOTHER

14. Maiden name Florence Gillard15. Birthplace Cumberland, Allegany, Md.16. Informant Robert Ruppert, Sr.Address 241 Columbia St., Cumberland, Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof 12-31-46
(month) (day) (year)Cemetery or crematory St. Peter & Pauls Cem.Location Cumberland

18. Funeral director

Address Cumberland19. Dec 31 19 46
(Date rec'd by registrar)Registrar J. P. Franklin, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 19 46, at 3:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-29 19 46 to 12-29 19 46
and that I last saw him alive on 12-29 19 46

Immediate cause of death

pneumonia (bacterial)

DURATION

14 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE _____

M. D. or other

Address 59 Seane St. Date signed 12-29-46

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

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DATE OF REGISTRATION

PLACE OF REGISTRATION

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

RECEIVED

JAN 3 1947

BUREAU

438

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82a

CERTIFICATE OF DEATH

11681
Reg. Dist. No.

40

1. PLACE OF DEATH:

County..... Allegany
City or town..... Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Life
Hospital, institution or street address where death occurred:
Killcrest Drive, Baltimore Pike
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland..... County..... Allegany
City or town..... Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Straal No..... Killcrest Drive, Baltimore Pike
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Henry Shriver II

3. (b) Social Security Number

217-14-4012

4. Sex..... Male..... 5. Color or race..... White..... 6.(a) Single, married, widowed, or divorced..... Married.....
6.(b) Name of husband or wife..... Henrietta Swartzwelder
6.(c) If alive, give age..... 70..... years
7. Birth date of deceased (mo., day, yr.)..... October 10 1874
8. AGE: Years..... 72..... Months..... 2..... Days..... 21..... hrs..... min.....

9. Birthplace..... Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation..... President
11. Industry or business..... First National Bank

12. Name..... Henry Shriver
13. Birthplace..... Cumberland Md

14. Maiden name..... Sarah Perry
15. Birthplace..... Cumberland Md.

16. Informant..... Henry Shriver III
Address..... Cumberland, Md.

17. Burial..... Date thereof..... 1/2/47
(Burial, cremation, or removal. Which?)..... (month) (day) (year)
Cemetery or crematory..... Rose Hill Cemetery
Location..... Cumberland, Md.

18. Funeral director..... William H. Kight
Address..... Cumberland, Md.

19. Jan 1, 19 47 J.P. Franklin, M.D.
(Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 31, 19 46, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44, to 12-31-19 46
and that I last saw him alive on 12-28-46

Immediate cause of death..... Cerebral Apoplexy
DURATION..... 5 days

Due to.....
Due to.....

Repeated Cerebral Apoplexy
Other conditions..... stroke in past few years.
(Include pregnancy within 8 months of death)

Major findings of operations..... none
Date of op.....

Autopsy results..... none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicida, or homicida..... Date of.....
Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE..... J.P. Franklin
M. D. or other.....
Address..... Date signed 12-31-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13311

RECEIVED

JAN 3 1947

1-55

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Diat. No. 40

11682

1. PLACE OF DEATH:
County Allegany
City or town Near Cumberland rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 years
Hospital, institution, or street address where death occurred:
Rural LaVale, P. F. D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural LaVale, P. F. D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Cora Mae Shroyer
3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Lewis D. Shroyer

7. Birth date of deceased (mo., day, yr.) September 29, 1874
6. (c) If alive, give age _____ years

8. AGE: Years 72 Months 2 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Valley, Pa
(Town, county, and state)

10. Usual occupation House

11. Industry or business "

12. Name John T. Rice

13. Birthplace Cumberland Valley, Pa

14. Maiden name Elizabeth Brant

15. Birthplace Cumberland Valley, Pa

16. Informant Mrs. Lawerence Ellsworth

Address Rural, LaVale, Cumberland, Md.

17. Burial Date thereof 12/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Dec 19 46 J. P. Faulkner, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 19 46 at 9-30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 44 to December 16 19 46
and that I last saw him alive on December 8 19 46

Immediate cause of death Congestive heart failure

Due to Chronic myocarditis

Due to _____

Other conditions Dehiscence

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. K. King M.D. M. D. or other

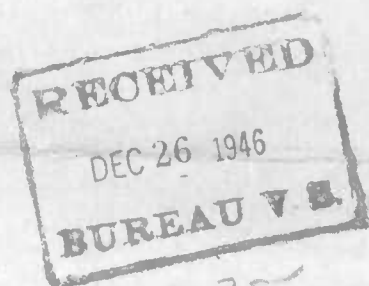
Address B. E. Green Date signed 12-18-46

DURATION
4 months
2 yrs
3 yrs

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Job)

CERTIFICATE OF DEATH

11868

100

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Union, St. Lawrence Co. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Butler
City or town Union, Pa.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

John Shipper, Jr.

3. (b) Social Security Number

✓

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elizabeth C. Neal

6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Mar. 3rd 1897

8. AGE: Years 49 Months 9 Days 24 hrs. min.

9. Birthplace Robertsdale, Mustang, Pa.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Coal mines

12. Name John Shipper

13. Birthplace Pa.

14. Maiden name Katherine C. Poulson

15. Birthplace Springfield, Pa.

16. Informant Miss Susan C. Neal

Address Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12-29-1946
(month) (day) (year)

Cemetery or crematory Mt. Savage Md.

Location Methodist Cemetery

18. Funeral director Jacob Wagner

Address Westbury, Pa.

19. Dec. 28 1946 Vernon McDermott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26th 1946 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24th 1946 to Dec-26th 1946 and that I last saw him alive on December 26th 1946

Immediate cause of death Lobar Pneumonia. DURATION 1 week.

Due to

Due to

Other conditions Chronic nephritis Insipiente

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mans of injury Injured at work?

23. SIGNATURE Wm. E. Mosley M. D.

M. D. or other

Address Mt. Savage Md. Date signed 12/27-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 6 1947

BUREAU V. H.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (950)

CERTIFICATE OF DEATH

11683

Reg. Diat. No. 60

1. PLACE OF DEATH:

County Allegany.City or town Dawson.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State SAME countyCity or town
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Ray Ellsworth Slider.

3. (b) Social Security Number

234-40-2808

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Sept. 8, 1925.

8. AGE:

Years

Months

Days

If less than one day

21225

hrs.

min.

9. Birthplace

Thomas, West Va.

(Town, county, and state)

10. Usual occupation

Pulp Tester

11. Industry or business

West Va. Pulp and Paper Co.

FATHER

12. Name

Ray E. Slider

13. Birthplace

Dobbin, Maryland.

MOTHER

14. Maiden name

Thelma Derham

15. Birthplace

Cross, West Va.

16. Informant

Mrs. Thelma Slider,

Address

Dawson, Maryland.

17.

Burial

Date thereof

Dec. 5, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Dawson Cemetery.

Location

Dawson, Maryland.

18. Funeral director

W. Harold F. Jellison Jr.

Address

Piedmont, West Va.

19.

Dec. 5W. H. Jellison Jr.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1946, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4, 1946, to Dec. 3, 1946and that I last saw him alive on Dec. 2, 1946

Immediate cause of death

Arteriosclerosis

DURATION

3 days

Due to

Cardiac Heart failure

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Jellison Jr.

M. D. or other

Address

West Virginia

Date signed

12/5/46

RECEIVED

DEC 6 1946

BUREAU V.S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

11684

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

313 Water St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 313 Water St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Florence Virginia Steppe

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Joseph W. Steppe

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 18718. AGE: Years Months Days If less than one day
75 2 8 hrs. min.9. Birthplace Fort Ashby, W. Va.
 (Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Noah Long13. Birthplace Maryland14. Maiden name Mary Logston15. Birthplace Unknown16. Informant Mr. Joseph W. SteppeAddress 313 Water St. Cumberland, Md.17. Burial Date thereof Dec. 7, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S.S. Peter & PaulLocation Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Dec 6 1946 J. C. Franklin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1946 at 3:05 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3, 1942 to Dec. 4, 1946 and that I last saw him alive on November 25, 1946Immediate cause of death congestive heart failure DURATION 6 weeksDue to chronic myocarditis 2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. H. Hines M. D. or otherAddress 59 Greene St. Date signed 12-5-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 10 1946

BUREAU OF

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

MEB Owens
11685

1. PLACE OF DEATH:

County allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
310 Waverly Terrace
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Waverly Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George Weakly Stevens

3. (b) Social Security Number

214-07-1357

4. Sex 5. Color of race 6.(a) Single, married, widowed, or divorced

Male White Widowed
Nellie Wheeler

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1880

8. AGE: Years Months Days If less than one day
66 10 21 hrs. min.

9. Birthplace Frostburg, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Retired Printer

11. Industry or business Linotype Operator

12. Name W. B. Stevens

13. Birthplace California

14. Maiden name Nellie Brown

15. Birthplace Hyndman Pa.

16. Informant Laura Krieger

Address 310 Waverly Terrace Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16, 1946
(month) (day) (year)

Cemetery or crematory Res Hill Cemetery

Location Cumberland Md.

18. Funeral director John J. Haffey

Address Cumberland, Md.

19. Date rec'd by registrar Dec 16, 1946 Registrar J. P. Faulkner, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 19 46 at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 19 45 to Dec 14 19 46

and that I last saw him alive on Dec 14 19 46

Immediate cause of death

Coronary occlusion

Due to Arterio sclerosis

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE MEB Owens

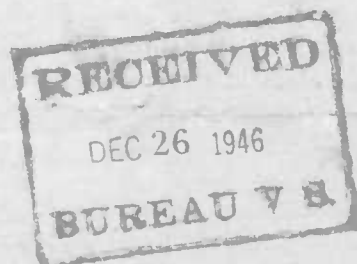
Address 133 Va ave

Date signed 12/16/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1168640

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 yrs.
 Hospital, institution, or street address where death occurred:
113 Laing Ave
 How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 113 Laing Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mrs Verna May Stevenson

3. (b) Social Security Number

gone

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife George Stevenson
 6. (c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) Sept 4, 1893
 8. AGE: Years 53 Months 3 Days 4 If less than one day
 hrs. min.

9. Birthplace Midlothian, Allegheny Co. Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at home

12. Name John H. Wilson

13. Birthplace Midlothian, Md.

14. Maiden name Alfretta Lee

15. Birthplace Graham, Md.

16. Informant George Stevenson

Address 113 Laing Ave - Cumberland

17. (Burial, cremation, or removal, which?) Burial Date thereof Dec 12, 1946
 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart Md.

18. Funeral director John D. Zager

Address Cumberland Md.

19. Dec. 11, 1946 J. P. Franklin M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 19 46 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 15 19 43 to Dec. 8 19 46
 and that I last saw him alive on December 7 19 46

Immediate cause of death Cardio-vascular - renal disease
 DURATION years

Due to

Due to

Other conditions Tropic hypothyroidism 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE MEB Owens M. D. or other

Address 153 V. Ave. Cumberland Md. Date signed 12/9/46

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7-35-47

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

11687

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
 City or town Cumt Island
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs
 Hospital, institution, or street address where death occurred:
402 South St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumt Island
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 402 South St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Russell Earl Stewart

3. (b) Social Security Number

705-09-9881

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Bessie Miller

7. Birth date of

deceased (mo., day, yr.)

Dec 7 1888

6. (c) If alive, give age..... years

8. AGE:

58

Yeare

Monthe

Daye

It less than one day

18

hrs.

min.

9. Birthplace

Timberville Va.
(Town, county, and state)

10. Usual occupation

machinist

11. Industry or business

B & O R.R.

FATHER

12. Name

John B Stewart

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Virginia White

15. Birthplace

Va.

16. Informant

Mrs Russell E. Stewart

Address

Cumt Island Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Hillcrest Cem

Location

Cumt Island

18. Funeral director

Louis J. H. Inc

Address

Cumt Island Md.

19. Dec 27, 19 46

(Date rec'd by registrar)

J. P. Franklin M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1946, at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended the deceased from

Oct 15 1946 to Dec 25 1946and that I last saw him alive on 12/25/46 1946

Immediate cause of death

DURATION

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Williams M.D.

Address

Date signed 12/26/46Richard M. Williams, M.D.
MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Mothers

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11688
40

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

Allegheny HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 25 Oak St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary "Kozlechor" Strah

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Frank Strah7. Birth date of deceased (mo., day, yr.) December 8, 18838. AGE: Years 62 Months 11 Days 25 If less than one day
hrs. min.9. Birthplace St. Rupert, Austria
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name John Kozlechor13. Birthplace Austria14. Maiden name ?15. Birthplace Austria16. Informant Mrs. Mary BennettAddress 25 Oak St.17. Burial Date thereof December 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & Paul CemeteryLocation Cumberland, Md.18. Funeral director John J. HoffmanAddress Cumberland, Md.19. Dec 5 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1946 at 10:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov-30 1946 to Dec 3 1946
and that I last saw him alive on Dec-3 1946

Immediate cause of death

Shock -
Ch. Myocarditis

Due to

Due to

Due to

Other conditions Pneumo-pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE R. M. Maskeyst

M. D. or other

Address 49 Emme StDate signed 12-5-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 10 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 149-6

11687

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, 215 Decatur StreetHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MineralCity or town Ridgeley Rt. #1, W. Va.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Geraldine Teter

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Paul Teter

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

July 11, 1922

8. AGE:

Years

Months

Days

If less than one day

24529

hrs.

min.

9. Birthplace Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

William Beal

13. Birthplace

Penna.

MOTHER

14. Maiden name

Dora Shilling

15. Birthplace

Penna.16. Informant Allegany Hospital

Address

Cumberland, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 2, 1947
(month) (day) (year)

Cemetery or crematory

Hyndman Cem.

Location

Hyndman, Penna.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

Jan. 1, 1947J. P. Shanklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 19 46 at 1:39 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 29 19 46 to Dec. 30 19 46and that I last saw him alive on Dec. 30 19 46

Immediate cause of death

myocardial infarction

DURATION

12 hr

Due to

coronary atherosclerosis

Due to

coronary atherosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

coronary atherosclerosis
large baby Date of op. 12-30-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

L. Shilling M.D.
M. D. or other
Address 59 Greene St. Date signed 12-31-46

STATE OF TEXAS, DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

LOCAL HEALTH OFFICER

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Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11690

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegheny
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lyr
Hospital, institution, or street address where death occurred:
Cash Valley, R. F. D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Somerset
City or town Hyndman RD. #1 Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hyndman RD #1
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME
Mrs Mary E. Troutman

3. (b) Social Security Number

None

4. Sex Fe 5. Color or race W 6. (a) Single, married, widowed, or divorced
Widowed

6. (b) Name of husband or wife Benjamin Troutman

June 27 1865 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1865

8. AGE: Years 81 Months 5 Days 12 If less than one day
 hrs. min.

9. Birthplace Somerset Co Pa.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name Valentine Emerick

13. Birthplace Pa.

14. Maiden name Un Known

15. Birthplace "

16. Informant Mrs Nora Martin

Address Cumberland, Md. Rd #1, Cash Valley

17. Burial Comps Date thereof 12/11/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyndman, RD 1 Pa. Somerset Co.

Location H. H. Zeigler

18. Funeral director H. H. Zeigler

Address Hyndman Pa.

19. Dec 10, 46 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 19 46, at 7 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to Dec 9 19 46

and that I last saw him alive on Dec 9 19 46

Immediate cause of death Chronic Arterio-Sclerotic Heart Disease

DURATION

10 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Lappin M.D. M. D. or other

Address Hyndman Pa. Date signed 12-9-46

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 18 1946

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (460-2)

11691

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleganyCity or town Long, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
215 Decatur Street - Allegany Hosp.How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Near Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. Long, Kloosterman's Addition
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Girl Twigg

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

12/23/467:05 P.M.

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace

Allegany Hospital, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Claude Twigg

13. Birthplace

Old Town, Md.

MOTHER

14. Maiden name

Stella Agress

15. Birthplace

N. J.

16. Informant

Address

Mrs. Claude Twigg
Kloosterman addt. Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof Dec. 26, 1946
(month) (day) (year)

Cemetery or crematory

Hillcrest Cem.

Location

Cumberland, Md.

18. Funeral director

Address

Charles L. George
Cumberland, Md.

19.

(Date rec'd by registrar)

Dec. 26 46

19.

J. B. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 19 46 at 3 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 24 19 46 to 3:00 A.M. 19 46and that I last saw h. alive on Dec. 23 19 46

Immediate cause of death

respiratory failure

DURATION

Due to

premature birth

Due to

premature separation of the placenta

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

L. Rhine MD

M. D. or other

Address

59 Green St.Date signed 12-25-46

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JAN 7 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. **11692 40**

1. PLACE OF DEATH:

County **Allegany**
City or town **Cumberland**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **Life**
Hospital, institution, or street address where death occurred:
514 Reihl Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County **Allegany**
City or town **Cumberland**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **514 Reihl Avenue**
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

MRS. GERTRUDE WHITE

3. (b) Social Security Number

None

4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Divorced**

6.(b) Name of husband or wife **Elmer White**
6.(c) If alive, give age **70** years

7. Birth date of deceased (mo., day, yr.) **April 28, 1878**

8. AGE: Years **68** Months **7** Days **27** If less than one day
.....hrs.min.

9. Birthplace **Cumberland, Allegany, Maryland**
(Town, county, and state)

10. Usual occupation **Practical Nurse**

11. Industry or business **Self**

12. Name **John Reihl**

13. Birthplace **Germany**

14. Maiden name **Martha Rompf**

15. Birthplace **Germany**

16. Informant **Mrs. Jesse Welch**

Address **514 Reihl Ave. Cumberland, Md.**

17. **Burial** Date thereof **12/28/46**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Rose Hill Cemetery**

Location **Cumberland, Md.**

18. Funeral director **William H. Kight**

Address **Cumberland, Md.**

19. **Dec 27 46** J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **December 25 1946** at **3 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan 1942** to **Dec 25 1946**
and that I last saw him alive on **3 am.**

Immediate cause of death
Chronic myocarditis
Cardiac asthma
Due to hypertension
Carcinoma of breast

DURATION

10 yrs
"
3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Charles A. Everhart M.D.** M. D. or other

Address **36 Moore St.** Date signed **12/27-46**
Cumberland Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PA TADIN A. 2nd

24-1947

13-1947

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 11693 48

1. PLACE OF DEATH:

County Allegany
City or town near Cumberland, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred: Rt. 2, near Baltimore Pike
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany
City or town near Cumberland, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 2, near Baltimore Pike
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Mrs. Niletta Blanche Wilkinson

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lester L. Wilkinson
6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 12, 1885

8. AGE: Years 61 Months 5 Days 26 It less than one day hrs. min.

9. Birthplace Huntington, Huntington Co., Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name William H. Lightner

13. Birthplace Huntington, Pa.

14. Maiden name Niletta Boyer

15. Birthplace Huntington, Pa.

16. Informant Lester L. Wilkinson

Address Rt. 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof December 11, 1946
(month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. (Date rec'd by registrar) Dec. 11, 1946 J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1946 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 a.m. to 8 a.m. and that I last saw her alive on 6 Dec.

Immediate cause of death Cerebral Hemorrhage DURATION 4 months

Due to arteriosclerosis
arterial hypertension, severe

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Dine M.D. or other

Address 110 S. Calhoun St. Cumberland, Md. Date signed Dec. 11, 1946

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

BUREAU 3

2-35

Reg. Diat. No. 6

County..... Allegany.....
City or town..... Westernport - rural.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 10 years.....
Hospital, institution, or street address where death occurred:
..... 1 mi north of Westernport, Md.....
How long in hospital or institution?.....

State Maryland County Allegany
City or town Franklin - rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 mi north of Westernport, MD
(If rural, give LOCATION)
2.(a) If veteran, name war

Thomas Glen Wilt

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
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6.(b) Name of husband or wife.....Lucinda Broadwater Wilt

7. Birth date of deceased (mo., day, yr.) July 7, 1881 6. (c) If alive, give age 51 yea

8. AGE:	Years	Months	Days	If less than one day
	65	5	15 hrs. min.

9. Birthplace Nr Barton, Garret, Maryland
(Town, county, and state)

10. Usual occupation.....FARMER

11. Industry or business

12. Name Peter Wilt

13. Birthplace _____

14. Maiden name Sarah Crow

15. Birthplace Avilton, Maryland

16. Informant.....Marshall Wilt.....

Address Franklin, Maryland

17. burial..... Date thereof..... Dec 24, 1944
(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory Shelton Cemetery

Location Westingport, Ind.

18. Funeral director..... Ellsworth S. Doal

Address 111 Church St. Westernport, Md.

19. Dec 23 1946 Waginkor M.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1946 at 7:00 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1946 Dec 22 1946 and that I last saw her alive on Dec 31 1946

Immediate cause of death.....	DURATION
<i>Myocardial Infarction</i>	<i>3 mo</i>

Out to: Arthur Schrier 34

Due to.....

Other conditions: Diabetes Mellitus 2/9

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. **VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Misses of Injury Injured at work?

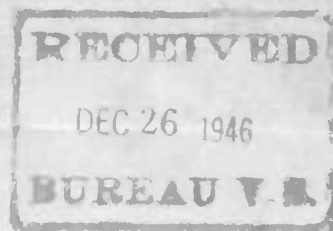
23. SIGNATURE

Address Quincy, W. Va. Date signed 11/23/66

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

Reg. Dist. No. 11695

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL, CUMBERLAND, MD.
How long in hospital or institution? 1 hr. 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
City or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. BOWMAN'S ADDITION
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

BABY GIRL WRATCHFORD

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife..... 6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) DEC. 14, 1946
8. AGE: Years Months Days If less than one day
1 hrs. 20 min.

9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name GLEN WRATCHFORD
13. Birthplace W. VA.

MOTHER 14. Maiden name REGINA MINTDROP
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial Date thereof Dec 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland, Md.

19. Dec 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 14 46 at 7:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14 to Dec. 14 1946
and that I last saw him or her alive on Dec. 14 1946

Immediate cause of death rematovity DURATION 5 m.

Due to.....

Due to.....

Other conditions.....

(Includes pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Hodge, M.D. (M.D. or other)

Address Cumberland, Md. Date signed 12/19/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and fully.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 514

11696

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH:

County Allegheny
City or town Cumtberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred:601 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Cumtberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 601 Bedford St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

William Carl Gilch

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Louise C. Armbruster7. Birth date of deceased (mo., day, yr.) November 22 18768. AGE: Years 70 Months - Days 14 It less than one day hrs. min.9. Birthplace Cumtberland Ind.
(Town, county, and state)10. Usual occupation Contractor11. Industry or business Brick & Tile Setters12. Name Conrad G. Gilch13. Birthplace Germany14. Maiden name Josephine Workman15. Birthplace Germany16. Informant Dr. Louise GilchAddress Cumtberland17. Burial Date thereof Dec 9 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Lukes Cem.Location Cumtberland18. Funeral director Louis Stein Inc.Address Cumtberland19. Dec 9 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 46 at 7 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3rd 46 to Dec 6 46and that I last saw him alive on Dec 2nd 46Immediate cause of death Carcinoma of prostate DURATION 18 mos.

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. T. Treaskis M.D. M. D. or otherAddress Cumtberland, Md Date signed Dec 7-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 18 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (472)

CERTIFICATE OF DEATH

11697
40
Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

16 South Front St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 16 South Front St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Phillip Mathias Zimmerman

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 11, 1869

8. AGE:

Years 77Months 6Days 28

If less than one day

hrs. min.

9. Birthplace

Cumberland, Md

(Town, county, and state)

10. Usual occupation

Clerk Retired

11. Industry or business

FATHER

12. Name

Conrad Zimmerman

13. Birthplace

Germany

MOTHER

14. Maiden name

Mary Gruber

15. Birthplace

Germany

16. Informant

C. C. Zimmerman M.D.

Address

Cumberland, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/11/1946

(month) (day) (year)

Cemetery or crematory

St. Luke's Ceme.

Location

Cumberland, Md.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19. (Date rec'd by registrar)

Dec. 11, 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 9, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-15-46 to 12-9-46and that I last saw him alive on 12-9-46

Immediate cause of death

Carcinoma of Larynx

DURATION

1 yr.

Due to

Due to

Carcinomatosis

Other conditions

6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 12-9-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 18 1946

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